

**SATISFACTORY, GOOD AND OUTSTANDING NURSES: PERCEPTIONS OF
NURSES, THEIR COLLEAGUES AND PATIENTS**

by

Kristina Medigovich

RN, BN (Hons), GradDipEd

This thesis is presented for the degree of Doctor of Philosophy at Murdoch University

February, 2012.

DECLARATION

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

Kristina Medigovich

Signature

Date

ABSTRACT

All nurses must accept responsibility for their own professional competence and performance but it is often the case that there is a large disparity between those nurses who perform very well and those who perform less well. The study was undertaken in response to the paucity of research findings to define what is an outstanding, good and satisfactory nurse, and how these differences in level of performance are enacted in clinical practice. The overall purpose of this study was to explore perceptions of the key attributes and characteristics of outstanding, good and satisfactory nurses practising in acute care clinical settings from the perspective of a number of stakeholders. The study was devised on the premise that this information would provide a significant basis for change in the way nurses are educated and assessed. A qualitative interpretive approach guided the study. Forty-six people were interviewed on their perceptions of the distinction between satisfactory, good, and outstanding nurses. The sample included patients, doctors, nurses, physiotherapists, social workers and occupational therapists, all of whom had recent or current professional contact with registered nurses. Subsequently, participants were again contacted to verify the findings of the first phase of the study.

There were discernable differences in participants' descriptions of satisfactory, good and outstanding nurses. Five distinct themes emerged in the data analysis regarding outstanding nurses. The major themes were: Sustaining a High Level of Performance, Modelling Exemplary Professional Behaviours, Balancing the Personal and the Professional, Managing Self and Others and Forming Personal and Therapeutic Relationships. 'Good' nurses were seen to perform well in the clinical setting with some

reservations. The five themes identified were Reservations about Clinical Competence, Limitations in Communicating, Inconsistencies in Working Collaboratively, Caring Style and Coping. ‘Satisfactory’ nurses were perceived to perform at a basic minimum standard which met patient safety standards. The major themes identified were Primarily Attending to Physical Care, Providing a Minimum Standard of Care, Selective Caring, Lack of Demonstrated Problem Solving Skills and Limited Personal and Interpersonal Capabilities.

This research study provides unique insights into how nurses are perceived by those who interact with them in the acute care clinical setting. The findings present unmistakable evidence that some nurses in clinical practice are outstanding, in particular at the ward/unit level within acute care general and mental health facilities. The outstanding nurses were not only considered high performing nurses, but they were able to facilitate and ensure a high level of performance from other staff members. Their professional behaviours were exemplary. They were also seen as having the ability to balance their personal and professional life so that problems or stressors in their personal life did not ‘leak’ across into their professional life. The outstanding nurses were not only good leaders, they were good managers, managing themselves and others. Prolific comments were forthcoming about how they were able to maintain relationships with others well, and they did so with effective communication strategies.

There was clear evidence that nurses who were perceived to be ‘good’ nurses performed well. At times there were limitations with this group of nurses, with some lacking the detailed specific knowledge and assessment skills of the outstanding nurse

and creating the impression that they were ineffective in some of their actions. However there didn't seem to be a compromise to patient safety.

Participants believed that when the nursing care provided was mainly physical in nature the nursing care was considered adequate. Satisfactory nurses were considered safe but not holistic in the nursing care they provided. They tended to focus on physical care, with limited attention to the psychosocial aspects of nursing. This left the impression that the satisfactory nurse was task orientated, principally able to follow a plan of care, much like a job list of tasks, which represented a narrow focus of practice. The findings of this study suggest a number of recommendations to enhance nursing education, improve clinical performance in the practice setting and extend nursing knowledge through further research. There is an immediate imperative to address the problem of underperforming nurses in the profession which may include ongoing national dialogue about how to identify students who may underperform in the fully fledged role of a registered nurse.

ACKNOWLEDGEMENTS

I am sincerely grateful for the support I have received and would like to start by thanking my supervisors Professor Anne McMurray and Professor Bronwyn Jones. Thank you for your unwavering support and guidance and your encouragement. I'd like also to give special thanks to my supervisors for their steadfast patience over this long journey.

The completion of this thesis would not have been possible without the encouragement of a good friends and family who have supported me and my work over the past years.

I'd also like to make mention and offer thanks to the outstanding educators and researchers within Murdoch University's School of Nursing and Midwifery who helped me with advice and words of encouragement.

Finally, to the participants who took the time to participate in this study and give me some insight into your experiences, thank-you.

TABLE OF CONTENTS

	Page
TITLE PAGE	i
DECLARATION	ii
ABSTRACT	iii
ACKNOWLEDGEMENTS	vi
TABLE OF CONTENTS	vii
LIST OF TABLES	xiii
LIST OF FIGURES	xiv
CHAPTER ONE	1
SETTING THE SCENE: THE RESEARCH IN CONTEXT	1
Introduction to the Study	1
Background to the Study	5
Significance of the Study	6
Purpose of the Study	9
Research Questions	9
Clarification of Terms	10
Nurse	10
The Outstanding Nurse	11
The Good Nurse	11
The Satisfactory Nurse	11
Perceptions	12

Competence	12
Structure of the Thesis	12
CHAPTER TWO: LITERATURE REVIEW	14
Introduction	14
Search Strategy	15
Nursing and Caring	16
Satisfactory, Good and Outstanding Nurses	19
Descriptions of Good Nurses	19
Descriptions of Outstanding Nurses	27
Descriptions of Excellent Nurses	28
Expertise in Nursing	29
Personal Qualities and Characteristics	33
Competence	35
The Meaning of Competence of Nurses	36
Behaviourist concept of competence	37
Generic concept of competence	37
Integrated or holistic concept of competence	38
Competence in the Australian Context	39
Continuing Competence in Nursing	41
Clinical Competency Education for Nurses	43
Role Performance	45
Beyond Competence	46

Beyond Competence - The Limits of Competence	46
Beyond Competence – Complexity and Capability	48
Capability	50
Summary	51
Framing the Study	52
 CHAPTER 3: METHODOLOGY	 56
SECTION ONE – THE RESEARCH PARADIGM	
Introduction	56
Research Paradigm and Philosophical Underpinnings	58
Interpretive Paradigm	60
Interpretation	60
Critical Incident and the Everyday	63
The ‘Voice’ in This Thesis	64
The Interviews	65
Rigour in Qualitative Research	67
Trustworthiness	67
Credibility	68
Transferability	68
Dependability and Confirmability	69
Auditability	69
Positioning the Researcher	70
The Researcher as Instrument of Inquiry	70

SECTION TWO – METHODS	72
Study Settings	72
Sample	73
Recruiting Participants	74
Data Gathering	77
Interview Process	79
Field Notes	81
Ethical issues	81
Data Analysis	83
Participant Verification	86
Summary	89
 CHAPTER 4: FINDINGS	 90
Introduction	90
Demographic Data	90
Thematic Analysis: Outstanding, Good and Satisfactory	95
Outstanding Nurses	97
Theme One: Sustaining a High Level of performance	98
Theme Two: Modelling Exemplary Professional Behaviours	108
Theme Three: Balancing the Personal and Professional	112
Theme Four: Managing Self and Others	116
Theme Five: Forming Personal and Therapeutic Relationships	125
The Outstanding Outlier	131

The Good Nurse	132
Theme One: Reservations about Clinical Competence	133
Theme Two: Limitations in Communicating	135
Theme Three: Inconsistencies in Working Collaboratively	137
Theme Four: Caring Style	138
Theme Five: Coping	140
Exceptions to Descriptions of ‘The Good’ Nurse	141
The Transitioning Nurse	141
The Satisfactory Nurse	143
Theme One: Primarily Attending to Physical Care	145
Theme Two: Providing a Minimum Standard of Care	147
Theme Three: Selective Caring	152
Theme Four: Lack of Demonstrated Problem Solving Skills	156
Theme Five: Limited Interpersonal Relationship Skills	158
Summary	163
 CHAPTER 5: DISCUSSION	 165
THE SEARCH FOR EXCELLENCE	165
Introduction	165
Participants’ Perspectives: Satisfactory, Good and Outstanding Nurses	166
Sustaining a High Level of Performance	167
Modelling Exemplary Professional Behaviours	170
Balancing the Personal and Professional	171

Managing Self and Others	174
Forming Personal and Therapeutic Relationships	176
Good Nurses as Compared to Outstanding Nurses	177
Reservations about Clinical Competence	177
Limitations in Communication	178
Inconsistencies in working collaboratively	178
Caring Style	179
Coping	180
Satisfactory Nurses as Compared to Good and Outstanding Nurses	182
Primarily attending to physical care	182
Providing a minimum standard of care	183
Selective Caring	183
Lack of demonstrated problem solving skills	186
Limited personal and interpersonal capabilities	187
Shared Understandings	188
Differing Perceptions	191
Nature of Communication Limitations	192
Making Critical Professional Judgements to Solve Patient Problems	192
Gradations in Participant Perceptions of Performance	194
Conceptual Issues Related to the Findings	196
Study Limitations	197
Meeting the ANMC Competency Standards	198
Summary, Recommendations and Conclusions	201

Summary	201
Recommendations	203
Recommendations for Clinical practice	203
Recommendations for Education	206
Recommendations for Further Research	208
Conclusion	211
REFERENCES	213
APPENDICES	235
Appendix A: Consent Form – Phase I	236
Appendix B: Demographic Questionnaire	237
Appendix C: Summary of Findings	239
Appendix D: Consent Form – Phase II	242
Appendix E	248

LIST OF TABLES

TABLES	Page
Table 4.1 Overall Participant Demographic Information	91
Table 4.2 Practitioner Demographics	92
Table 4.3 Patient Demographics	93
Table 4.4 The Outstanding Nurse Themes	96
Table 4.5 The Good Nurse Themes	132
Table 4.6 The Satisfactory Nurse Themes	145

LIST OF FIGURES

Figure	Page
Figure 2.1 Spiral of nursing capabilities development	54

CHAPTER ONE

SETTING THE SCENE: THE RESEARCH IN CONTEXT

Introduction to the Study

There are numerous views about what makes a great nurse. The notion of distinctions between satisfactory, good and outstanding nurses is understood within the profession. However, identifying and defining the characteristics and qualities of satisfactory, good or outstanding nurses is more difficult. These evaluative descriptors of nurses are also not fully conceptualised within the nursing literature and therefore various perceptions of satisfactory, good and outstanding nurses can only be inferred from published literature. A search of the nursing literature (reported in the next chapter) uncovered only a limited number of research studies that attempt to explicate in some ways what is an outstanding nurse and a good nurse. Many previous studies have predominantly focused on nursing care and singular aspects of that care such as the nurse – client relationship. As long ago as 1994, Fosbinder studied one particular aspect of that relationship, interpersonal competence and how interactions between patient and nurse might influence the patient's perceptions of quality care and satisfaction with care (Fosbinder, 1994). Others have also addressed competence in other dimensions, for example, in skills development (Benner, 1984).

The study reported here sought a broader and more comprehensive interpretation of the satisfactory, good and outstanding nurse. The study was undertaken to identify the qualities, nursing characteristics and attributes ascribed to

outstanding, good and satisfactory clinical nurses as perceived by nurses, patients, medical staff and allied health personnel. The genesis for the research began from my experiences of clinical practice and the relationships formed within the clinical environment. Throughout 30 years of experience as a clinician I have been both participant and observer in the changes that have been introduced to the role of the clinical nurse during that time and how that is expressed in the day to day world of the nurse.

An increasing number of industries operate in a dynamic and changing environment. Health care organizations are no exception, as they must answer the challenge of containing costs whilst providing effective, economical, quality care. With increasing complexity in the health care, the role of the nurse has become extended beyond providing direct nursing care, to interacting with many other health professionals to ensure a multidisciplinary high quality team approach to patient care. This level of care complexity, staff shortages, high levels of patient acuity and the quality agenda have led to the intensification of work and considerable challenges to provide effective, high quality, safe care in an environment of cost containment.

All nurses must accept responsibility for their own professional competence and performance but it is often the case that there is a large disparity between those nurses who perform very well and those who perform less well. This study has been developed to examine the role of the clinical nurse and issues surrounding the quality of patient care, and the professional needs and development of nurses in clinical practice in the hospital setting.

The assumptions of the research are as follows:

- The contact that participants have had with registered nurses will enable them to describe nursing behaviour, skills and attitude which reflects satisfactory, good and outstanding nurses.
- The individual nurse can and does make a difference in peoples' lives irrespective of the employing organisation and the prevailing conditions of the bureaucracy.
- There is a link between the way individual nurses enact the role and the quality of care the patient receives beyond the adherence to predetermined prescriptive policies and protocols that mandate minimal required standards of care.
- If the nursing characteristics and attributes of satisfactory, good and outstanding nurses are explicated then this will inform educators about what changes are required in the curriculum to help nursing students identify how they might direct their own development, be it personal or/ and professional.
- The findings will identify for practising registered nurses that there are clear ways to improve as a nurse which entails more than competence with clinical skills.

An interpretive approach was used in this study to fully explore the perceptions of recipients of care and colleagues in relation to the different levels of practice by satisfactory, good and outstanding nurses. The participants in this study are therefore individuals who have had previous or current contact with nurses. There were discernable differences in participants' descriptions of satisfactory, good and outstanding nurses, and these different perspectives are interpreted as unique and

common views of nurses' activities and the implied knowledge and capabilities underlying their activities. In previous studies describing one or some aspects of nursing care, patients have described aspects of the nurse patient relationship. Fosbinder (1994) for example, studied the interpersonal competence of nurses from the perspective of patients, and McCabe (2004) examined how nurses communicate from the patient's perspective. Because these studies investigated the nurse patient relationship from the patients' perspective they focused on a narrow range of attributes.

In the study reported here, health professionals as well as patients were asked to provide rich descriptions of their encounters with registered nurses in the clinical setting. It is the first known study which sought to explicate a comprehensive picture of satisfactory, good and outstanding nurses and how they carry out their professional role as registered nurses in the clinical setting.

The findings identified a range of outstanding, good and satisfactory nurses' nursing characteristics and attributes. Importantly, the findings illuminate how nurses might make changes to their own nursing performance so as to develop higher levels of capability, and strive for outstanding performance in clinical practice. Health care settings are constantly evolving into highly complex organisations, and along with these structural changes have come changes to the nurse's role. This study is original and significant as it identifies the attributes and characteristics of clinical nurses in the context of practice, which incorporates the breadth and reality of contemporary practice.

Background to the Study

Nurses are an essential component of the health care workforce, and practise in a variety of settings including clinical areas, educational institutions, administration areas and research centres. In Australia, 283, 087 nurse clinicians are employed (Australian Institute of Health and Welfare, 2010). The majority of nurses are employed in clinical settings within hospitals, mainly in the public sector (Australian Institute of Health and Welfare, 2010).

Nurses are fundamentally concerned with the physical care and comfort of patients. Henderson defines nursing as being primarily concerned with ...“helping people (sick or well), in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge...” (2006, p 20). Taylor (1994) describes nursing simply as that which happens between patients and nurses in contexts of care. For the most part nurses do not practise in professional isolation. Nursing is carried out within the context of interdisciplinary and multidisciplinary teams and nurses form professional relationships with other occupational groups within the hospital setting to provide the best possible care for the patients. In addition, there are many other less well recognized facets to the clinical nurses’ role. These aspects of nursing practice have been described as coordination of care, managing the bureaucracy, providing leadership and clinical judgement (Booth & Waters, 1995; McWilliams & Wong, 1994). A body of knowledge suggests that the clinical nurse role is more than the provision of direct patient care, and it may be influenced by the nurse’s personal qualities as well as the clinical context. Coulon and colleagues (Coulon, Mok, Krause & Anderson, 1996) recognized that nurses also bring critical human attributes to their work. They described these as enabling personal qualities

and maintaining nurse-patient relationships, and nurse-health team relationships, which are important in the pursuit of excellence in nursing.

Significance of the Study

The study is significant in four ways. First, the significance of the study lies in the question, Is clinical competence enough? Competencies are currently measured through learner assessment and performance management tools which place emphasis on clinical competence related to knowledge and skills. The competencies usually follow the model of adherence to pre set clinical standards or protocols that encourages reproduction rather than creativity. This poses the question: Is that enough to ensure high quality patient care?

An ultimate goal of nursing is to provide quality nursing care to patients. Quality nursing care can best be achieved by nurses delivering an optimum standard of care. If quality nursing care is to be delivered by nurses then it is necessary that the nurse who delivers the care be competent in the performance of her/his practice. As well, the nurse needs to be good enough in all the professional competencies. These have been identified by the Australian Nursing and Midwifery Accreditation Council (ANMAC) as a basis for assessing the beginning practitioner. The competency domains are; professional practice, critical thinking and analysis, provision and coordination of care and collaborative and therapeutic practice (Australian Nursing & Midwifery Council, 2005). While the competency statements articulate the standards, attributes and capabilities that those possessing nursing qualifications should be able to demonstrate, they are also very broad.

The qualitative research literature indicates that there are qualities and attributes which in addition to clinical competence, enhance perceptions of outcomes

of nursing practice. The quality of patients' care, and, hence outcome, depends greatly upon the people providing the care, so the *effectiveness of the staff* is a function of other factors besides their technical expertise. It is therefore important to identify more clearly the attributes and nursing characteristics which can enhance quality patient care.

Secondly, by determining the attributes of good and outstanding nurses, valuable knowledge will be gained about nurses, in order to inform nurse educators of the potential for nursing curricula change. As they read this study they may also become sensitized to the value of narratives and descriptions of nurses in practice, as a guide to developing teaching tools.

Thirdly, the findings of the study may also assist employers with nurse selection and assist in identifying professional development needs of registered nurses. All nurses aspire to develop further skills and knowledge as they mature in their practice, and clearly, explicating attributes worth adopting will aid in the professional development of registered nurses. The notion that an outstanding nurse will be better able to deliver this care is implicit in the current view of maintaining quality of nursing practice. It is not implicit that all nurses are outstanding or will be outstanding. However, there is an expectation that nurses whose performance is less than outstanding, should incorporate into their practice, skills, which will, in turn, contribute to quality care. These attributes may be seen as both personal and professional in nature.

Insufficient research attention has been devoted to a description of what constitutes excellence in a nurse. Benner (1984), identifies that there are differences between experienced nurses and expert nurses, the former (experience) being a pre requisite for the latter (expert). Although Benner's research provided many examples

of expert nurses using knowledge and clinical decision making, she did not identify a comprehensive picture of excellence. Rather, excellence was inferred in the expert nurses' narratives.

Fourthly, this study helps make visible the often hidden work of clinical nurses in the hospital setting. It increases the value of nurses and nursing by disclosing what is embedded in their clinical practice. It informs the practitioner of what is required in the contemporary role of a registered nurse to strive for good and excellent practice. Practitioners who find that they perform in similar ways to those described as good and outstanding nurses may feel reassured about their performance as clinical nurses.

The traditional approach to conducting research with nurses, nursing and nursing care has been to include in studies, participants who are the recipients of nursing care from specific specialty areas and/ or the peer group of the nurses under study. This current study was not confined to a specific specialty or group. Instead participants were drawn from a wide range of colleagues and recipients of care. This was intended to provide a more detailed and widespread investigation to clearly establish characteristics and attributes that would describe satisfactory, good and outstanding clinical nurses in keeping with the multifaceted role of clinical nurses who now provide care to patients within a more inclusive and collaborative approach with other health professionals. Exploring the perceptions of satisfactory, good and outstanding nurses in this way was aimed at advancing practice knowledge and providing direction for further research in this area. It is hoped that information from this study will be of particular use to the nursing profession, where new perspectives on the professional role of the registered nurse in the clinical setting are needed, to meet the demands of health care in the 21st century.

Purpose of the Study

In the background section of this chapter, I have provided several arguments highlighting the need for a clearer understanding about what is an outstanding, good and satisfactory nurse. The overall purpose of this study was to describe the key attributes and characteristics of outstanding, good and satisfactory registered nurses practising in clinical settings. The study emerged from the ongoing discourses about the subjectivity of assessment (Bradshaw, 1997; Bradshaw, 1998; Bradshaw, 2008;) and the growing number of qualitative studies which identify: attributes of good and ‘good enough’ nurses (Allan 2001; Davis, Hershberger, Ghan, & Lin, 1990) outstanding nurses (Kendall, 1999; Stiles, 1990) characteristics of nurses providing quality nursing care (Williams, 1996); excellence in nursing (Coulon et al., 1996) and nursing competencies of effective nursing performance (Zhang, Luk, Arthur, & Wong, 2001).

Research Questions

Three research questions aimed to elicit the participants’ perceptions of the attributes and characteristics that define a satisfactory, good and an outstanding nurse and their behaviours and characteristics.

1. How do patients, nurses and medical and allied health personnel describe satisfactory, good and outstanding nurses?
2. What is the shared understanding of what constitutes a satisfactory nurse, a good nurse and an outstanding nurse?
3. What are the differences in perceptions about what is a satisfactory nurse, a good nurse and an outstanding nurse?

These questions served to indicate the direction of the study and set up a boundary for the enquiry. The participants' descriptions and perceptions about outstanding, good and satisfactory nurses were explored with the above research questions in mind. The participants were asked to respond by reflecting on their experiences in the clinical setting. As nursing is a practice profession participants were asked to relate experiences about nurses they had encountered in the clinical setting.

Clarification of Terms

Previous writings have identified some aspects of good, good enough and outstanding nurses (Alavi & Cattoni, 1995; Allan, 2001; Izumi, Konishi, Yahiro, & Kodama, 2006; Noble-Adams, 2001; Kendall 1999; Stiles, 1990) with some presenting the idealised nurse or their opinion as opposed to the observed nurse (Fabricius 1991; Rush & Cook, 2006; Smith & Godfrey, 2002). Davis et al (1990) have previously written of the being and doing of nursing in relation to a *telos* or ideal of nursing. The ideal nurse however may be influenced by the perceiver's expectations and may not resemble the 'actual nurse' as experienced in clinical setting. The following definitions and explanations were used to guide this study.

Nurse

Nurse is defined as any nurse registered in Division 1 of the register held by the Nursing and Midwifery Board of Australia, and practising in the area of clinical nursing. This includes general nurses, mental health nurses and comprehensive nurses.

The Outstanding Nurse

The outstanding nurse is one who stands out from the rest, a kind of ‘star’ (Kendall, 1999).

The Good Nurse

There is no general consensus or agreement on what is the meaning of the phrase good nurse. Good is a frequently used as a colloquial expression. It is often used in conjunction with other terms to express subjective opinions on the good mother (Vallido, Wilkes, Carter & Jackson, 2010), a good woman or, in this case a good nurse.

In a formal sense the words good and nurse have a relatively fixed interpretation in the lexicon of language. The phrase good nurse does not. The Oxford Dictionary (1989) provides a definition of good as the existence in a high, or at least satisfactory, degree of characteristic qualities that are either admirable in themselves or useful for some purpose. Therefore for the purposes of the study the good nurse is a highly competent nurse and has mastery over that which she/he is supposed to have, namely nursing practice. The term good in relation to nurse is used as an evaluative adjective.

The Satisfactory Nurse

Studies have not been conducted to explicate understandings about satisfactory nurses. The Oxford Dictionary (1989) describes the word satisfactory as meaning sufficient for the needs of the case, or adequate. Therefore the satisfactory nurse is at the least a competent nurse to the extent that she/he has been deemed competent to practise and is therefore registered by the national professional body.

Perception

Perception is defined as an understanding or view (Oxford English Dictionary, 1989). It is also defined as an interpretation or impression based upon such an understanding or belief. Perception, therefore, can be described as the process by which individuals organize and interpret their sensory impressions in order to give meanings to their environment.

Competence

The explication and definition of competence in nursing has proved to be elusive. Competence has multiple meanings in nursing. Competence encompasses more than just psychomotor skills (Benner, 1984). Competence when applied in the behavioural sense, refers to the functional adequacy and capacity to integrate knowledge and skills to attitude and values in a specific contextual situation of practice (Benner, 1984).

Structure of the Thesis

In this first chapter, background information, significance and purpose of this study have been introduced. Research questions which guide this study were also identified. An in-depth review of the literature in relation to understanding the key characteristics and qualities of outstanding, good and satisfactory nurses is provided in the following chapter. Chapter two also contains an explanation of the conceptual framework of the study. Chapter three outlines the theoretical underpinnings of the research and a discussion of the research methods used for the study. Chapter four contains the findings for the study. Chapter five contains a discussion of the

implications of the findings with reference to the literature and any previous research findings. Conclusions are drawn from this information. This chapter also includes recommendations for nurse education, and clinical practice as well as further research. The limitations of this study are also provided.

CHAPTER TWO

LLITERATURE REVIEW

Introduction

The literature review has three purposes. First, it will critique the body of literature related to descriptions of satisfactory, good and outstanding nurses. Second, it will review the literature related to competence-based nursing as it relates to education, practice and assessment. The third area of the chapter will include a review of the literature as it relates to complexity in health care and nursing, and the need for the development of not only competence and competency standards, but also capability in registered nurses. An explanation of the operational aspects of the literature search is described below.

A review of literature related to the descriptions of good and outstanding nursing practice, and the attributes and characteristics common to nurses practising at these different levels, suggested a number of key areas under researched or reported in the research literature. These key areas include (i) comprehensive descriptions of good nurses; (ii) descriptions of outstanding nurses; (iii) attributes of good or satisfactory nurses.

Criteria for Considering Research Reports for This Literature Review

Studies included in this section of the literature review were written in English and, because of the paucity of research literature in the area under study, there was no confinement of search dates. Studies reported in languages other than English could not be considered due to the cost of translation. *Inclusion Criteria was as follows:*

- Main focus or part of the focus of the paper was the demonstration of nursing care that extended beyond ordinary or satisfactory care.
- Studies identifying positive attributes of nurses in the context of nursing practice.
- Papers which focused on quality nursing care without identifying specific attributes of nurses.

Exclusion Criteria included the following:

- Research reports focusing on patient satisfaction outcome measures.
- Research or professional commentary focusing on moral dimensions of nursing or nurse caring.

Search Strategy

The search strategy included nursing journals, other health care journals, books and theses. Electronic databases such as EBSCO, MEDSCAPE, PSYCINFO, PROQUEST were used extensively. The cited literature was identified by three distinct methods of searching. Initially, the Cumulative Index for Nursing and Allied Health (CINAHL) within EBSCO was searched. The terms satisfactory, good and outstanding nurses were Boolean searched and the word nurses was changed to include the wildcard *. Therefore the truncated nurs* allowed broader terms for each keyword and thus a greater range of results. Second, the university library book catalogue was searched using the above keywords. In addition, Google scholar was used and results cross referenced to the university journal database to locate full references. Some reports and journal articles were obtained from other libraries. Finally, a manual haystack search was undertaken by randomly selecting nursing journals unavailable electronically at the home university, but available at the other

three metropolitan university libraries and browsed cover-to-cover. Any relevant secondary references were obtained.

The cited literature is drawn predominately from the previous 29 years, 1982 - 2011. The limited number of studies in the area of satisfactory, good and outstanding nurses necessitated the review of literature over a wide time period. In addition, seminal works have been cited as they are considered authoritative works on the topics under examination.

Nursing and Caring

To understand the distinctions between satisfactory, good and outstanding nurses it is instructive to return to the essence of what constitutes nursing. Nursing has been conceptualised in many different ways since the evolution of the first explanation by Florence Nightingale, who explained nursing as having an emphasis on the physical environment of the patient together with the importance of accurate observation (Nightingale, 1859). Nightingale advocated that nursing care of the ill was based on knowledge of people and their environment (Alligood, 2006; Pfettscher, 2006).

Nursing has been described as being the unique function of the nurse who assists the individual in the performance of activities that contribute to the individual's health, recovery or death when they are unable to do those activities unaided (Henderson, 1964; Tomey, 2006). These two conceptions of nursing are similar, Henderson elaborating on Nightingale's explanation. Nursing has also been described as being socially constructed to meet human health-related needs (Thorne & Patterson, 1998). Another explanation which is similar to the human science oriented notions of Nightingale, was provided by Meleis (2005) who described

nursing as a human science as well as a practice-orientated, health orientated, caring discipline.

The supremacy of caring has been stressed by a number of theorists including Benner and Wrubel (1989). Caring is an essential part of nursing and Leininger (1984) stated that it is the 'essence' of nursing. However, it has also been noted that the concept of caring lacks preciseness, which makes it a difficult concept to define in nursing (McCance, McKenna & Boore, 1997, McCance, McKenna & Boore, 1999). Caring has been described as an affect; an interpersonal interaction, a therapeutic intervention, a human state and a moral imperative (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006; Morse, Bottorff, Neander & Solberg, 1991; Morse, Solberg Bottorff, Neander & Johnson, 1990). To further explicate caring, a caring encounter was described by Halldórsdóttir and Hamrin (1997) as having three components to its structure. These were; the nurse was perceived as caring; there was a resulting mutual trust and caring connection, and there was a perceived effect of the caring encounter which involved a sense of solidarity, empowerment, well-being and healing. A meta-analysis of caring (Finfgeld-Connett, 2008) suggests that the process of caring is inferred to be a context-specific interpersonal process characterised by expert practice, interpersonal sensitivity and intimate relationships.

Until the 1960's there was an emphasis in nursing practice on physical care. During the 1970's a growing recognition of other dimensions of patient needs led to a reformulation of nursing care as encompassing psychosocial, spiritual and emotional dimensions (Armstrong, 1983). Another shift in nursing has seen the perception of the patient as changing from the object of nursing intervention to that of a complex subject of understanding and care. 'Care' remains the most important aspect of nursing. Caring has been described as both central to nursing (Leininger,

1984) and its essence (Leininger, 1984; Watson, 1979). The thematic dominance of caring in the nursing literature (Benner & Wrubel, 1989; Blockley, 1994; Kahn & Stevens, 1988; Marck, 1990; O'Berle & Davies, 1992) underscores the universal acceptance of caring as a core construct of nursing within which nurses seek to identify their role and its practices. In nursing, caring is premised on the relationship that is established between a nurse and a patient (Arnold, 1995; Jenks, 1993; Trojan & Yonge, 1993). Watson (1979) a prominent nurse theorist, has argued that caring can only be demonstrated and practised interpersonally; namely, in the context of a relationship that is established between the nurse and the patient. Caring, however, is not unique to nursing, and has been described as only constituting a part of nursing (Crowden, 1994).

Since 1984, a small number of quantitative instruments have been developed to measure the concept of caring in nursing (Watson, 2009). A 35 item caring dimensions inventory (CDI-35) from a comprehensive review of the nurse caring literature (Lea and Watson, 1996) was developed and tested by Watson and Lea (1998); Watson, Deary and Lea, (1999); Watson, Deary, and Hoogbruin, (2001); and Watson, Deary, Hoogbruin, Vermeijden, Rumeu, Beunza, et al., (2003). The psychometric properties of this instrument have been found to be sound; however, the instrument is essentially a measurement of nurses' responses to questionnaire items about caring practices extracted from the literature. This is limiting in terms of understanding the concept of caring, because the development phase of the instrument did not include an in-depth investigation of nurses' perceptions that may have elucidated more detailed information.

Other research has been conducted on specific attributes and nursing characteristics of nurses who perform well, however the research has focused on

nurses who work in some specialty areas. These specialty areas have included palliative care (Stiles, 1990), oncology (Kendall, 1999) and stomal therapy (Carville, 2003). Nurses who work in such areas as intensive care, general medicine, general surgical areas and operating room nurses have not been included in the previously conducted research. Therefore there is a lack of generalisability from the findings that could inform the practice of nurses who work in the many other areas of nursing. In addition, little research has been undertaken to identify the attributes and characteristics of nurses in the light of their varying performance levels.

Satisfactory, Good and Outstanding Nurses

Descriptions of Good Nurses

Attributes of nurses have been reported in the nursing and psychological literature, including studies of nurses who are considered good and those whose practice is inadequate. Morrison (1990, 1991) used personal construct theory (Kelly 1955) and the repertory grid technique to study the characteristics of the good nurse and nurses' self perceptions of caring among 'ward sisters and charge nurses'. Repertory grid technique is based on a structured interview where participants describe themselves using polarities such as likeness and unlikeness for the nurses' perception of themselves as, for example, effective and ineffective nurses (Wilson & Retsas, 1997a, 1997b) and the technique is only infrequently applied as a method of analysis in the literature.

UK researchers conducted a two phase study identifying 15 characteristics as being important attributes of a good nurse using the repertory grid methodology in the first phase of their study (March & McPherson, 1996). Seventy two participants were each given a list of eight role titles. These were: a good nurse, a bad nurse, someone who has nursed me well, someone who has nursed me badly, someone I

have enjoyed nursing, someone I have not enjoyed nursing, myself as a nurse and how I would like to be as a nurse. The 15 characteristics identified were polite, humour, consistent, caring, organised, patient, co-operative, intelligent, confident, communicator, hard worker, happy, friendly, motivated and calm. In the second phase of the study, nursing students and registered nurses (N = 565) ranked these characteristics in terms of their importance. Responses showed similarity between both groups except for significant differences between samples on five of the 15 characteristics: organised, patient, intelligent, friendly and motivated. No further attempt was made to identify how the variables might be linked together or whether profiles of good nurses could be developed.

The forced-choice nature of many instruments limits responses, raising questions about other factors which might be considered to be important by participants. In a forced choice format respondents are forced to give a positive or a negative response (Polgar & Thomas, 2000). While this simplifies the respondent's task and the researcher's analysis, important information about the topic being researched may be missed. The use of the neutral category, as in Likert odd number eg. 5,7,9 point scales, is also unhelpful, as the neutral or undecided category makes interpretation difficult (Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007).

Research to determine the characteristics of good and outstanding nurses has also been conducted in non Anglo Saxon countries such as Sweden and China, (Björkström, Johansson & Athlin, 2006; Davis et al., 1990). In the People's Republic of China, first year nursing students (N = 33) participated in a study investigating aspects of professional socialisation (Davis et al., 1990). The students were also asked to describe the characteristics of good and bad nurses. A content analysis

revealed many identified characteristics, including culture and situation specific characteristics such as revolutionary humanitarianism and public speaking skills. Because the participants were nursing students with limited clinical experience, the generalisability of the findings is limited to this group. The findings of this study are also embedded in culture, reflecting the opinions of Chinese nursing students, as was intended by the researchers. Additional involvement from other groups, such as patients and experienced clinical nurses, may have provided more comprehensive and multi-dimensional information about the characteristics of good nurses.

Swedish researchers (Björkström, Johansson & Athlin, 2006) used a longitudinal, five year survey study design to investigate what ‘being a good nurse’ meant to nursing students prior to graduation, and once they had graduated. An open ended questionnaire surveyed beginning nursing students (n = 164), those just before graduation (n = 123), and three – five years post graduation (n = 77). The findings of the study indicated that the meaning of ‘being a good nurse’ grows in complexity over time. The researchers also found that professional awareness increases over time, although professional development showed only small increases. A limitation of the study was that data were collected using an open ended questionnaire, which may have precluded gathering full and comprehensive data. This limitation was noted by the researchers who reported a potential for inadequate interpretation by those respondents who provided short answers.

A more recent Japanese study (Izumi et al., 2006) investigated 26 cancer patients’ perceptions of good nurses using a qualitative research design, with patient interviews. The study explored the characteristics of “the good nurse” from the Japanese patients’ perspective. The research question(s) were not reported. However, the stated aims were firstly, to identify the characteristics of the good nurse and then

to explore social and cultural factors underlying these views. The researchers also investigated similarities and differences within the Far East Asian region.

Participants were asked to answer the following question: What are the characteristics of a good nurse? Responses were audiotaped and analysed using van Kaam's phenomenological approach of using six operations of scientific and systematic explication (Izumi et al., 2006). These were described as listing and preliminary grouping, reduction, elimination, hypothetical identification, application and final identification. The researchers identified that the good nurse was "a person who related to the patients as a person and had professional comportment" (p E17). Four personal qualities of good nurses were identified: being a good person; presenting themselves as persons; being interested in patients as persons; caring for the patient as a precious and irreplaceable person. Professional comportment was identified as being about competency and disposition. It is interesting that the study failed to provide any information about the clinical competence of the nurses beyond that of providing skilful communication, technical care and physical care. The researchers noted that an overwhelming number of descriptions revolved around the human or personal aspects of the good nurse. Examples of skilful physical care were; giving injections without causing pain, and taking blood from difficult to bleed patients. These two skills, identified as competencies by the researchers can be categorised as tasks. Special knowledge was mentioned by patients; however, the examples given were related to communicating information and explanations to patients. A limitation in only having patients in a study of this nature is that patients are not able to comment well on the specific nature and level of the nursing knowledge and expertise, which predictably leads to a focus on the tasks required, communication ability and interpersonal relating of nurses. The authors report that

the descriptions obtained in the study help to uncover culturally sensitive ethical values in nursing among Asian countries. This was represented by the *kangi* character of “*hito*-person”. The character symbolises that people are related and lean on each other for support (Izumi et al., 2006), and this represented to one patient the mutual caring aspect of the nurse-patient relationship in Japan which may or may not reflect interpersonal relationships of nurses and patients in other countries.

A limited number of studies reported findings about the characteristics of good nurses in the context of investigating other matters about nurses and nursing. One study was conducted for the Trust Board of the West Dorset General Hospital National Health Trust (WDGH NHS) in the United Kingdom (UK). Graham, Partlow and Maxwell (2004) called their report “What makes a good nurse?” The specific aim of the project was to identify the activities and functions of registered nurses at the WDGH NHS that staff and members of the public valued. The objective was to identify the work in which registered nurses should be engaged, the aspects of their role valued by patients, and the health care teams of which they are a part. Focus groups were conducted with fifty-nine registered nurses and representatives of all other hospital workers. Some of the findings reflected aspirations rather than facts, which was a limitation in that current practice was not described. For example, responses included: ‘nurses should be making decisions about treatment and care’ (p 71), and ‘nurses should be involved in professional issues, leadership’ (p. 71). A further limitation of the study was that only three members of the public representing the patients’ perspective could be recruited into the study. Therefore, staff participants who had been patients in hospitals responded from the perspective of both staff and patients, which may have confounded the findings. Allen, Frasure-Smith and Gottlieb (1982) conducted a study to evaluate the

effectiveness of 'responsive nursing', compared to other styles of nursing.

Responsive nursing was seen to be nursing practice which has five characteristics.

These are : a focus on the health of the patient within the context of the family over an extended period of time; an exploratory approach to collect patient information; developing a plan of care based on the patient's potential strengths, implementing a plan of care which addresses patient needs, and evaluates the plan of care based on patient responses. Effectiveness was considered to be the number of episodes of assistance with life events.

The purpose of Graham et al., 's (2004) study was to investigate what kind of nursing behaviours make the most difference to the health outcomes of patients located in family medicine units attached to university hospitals. In order to collect evidence to determine the nature of nursing in the three settings, conversations between the nurses and patients were tape recorded. In addition, individual nurses were interviewed about patient health problems, the corresponding nursing goals, and the method the nurse was following to reach these goals. The researchers established that patients in the demonstration unit (47% of total number of patients) felt that their nurses had tried to help them deal with a significantly greater percentage of life events than the patients in the two comparison settings (replacement of the physician and assistant to the physician styles of care). This study established that responsive nurses were effective in helping the patient deal with stress-related events. However, the title of the journal article was "What makes a good nurse?", and this was not established well by the evidence presented in the paper. The five items of evidence presented were the responsive nurse: spends more time with the client; is a supportive listener; is more likely to focus on the health aspects of the client; has individualised goals of care for the patient and, when with

the client, focuses on discussion and listening. The number of nurses and patients participating in the study is not reported and the location of the participating sites is not identified, although the researchers were from named Canadian universities. Because the findings were derived from a study conducted in family medicine units, they may not be generalisable to an acute care setting.

Allan (2001) concluded that patients at times may think that their nursing care has been just adequate compared to what they expected and expectations about the nurse may not be based in the 'real world'. An ethnographic study conducted by Allan (2001) in the United Kingdom investigating caring and non caring behaviours, found that patients' descriptions of nurses seemed unreal, and that the nurses the patients wanted were fantasies of a nurse who was ideal. This fantasy nurse co-existed with the real nurse, who, according to patients' accounts, was described as 'good enough'. The 'good enough' nurse was able to 'be there' in the background conveying emotional awareness while attending to the practicalities. The study was conducted in a fertility clinic with 15 patients and 23 nursing staff. Allan (2001) suggests that caring can be described as 'emotional awareness', and non-caring as 'emotional distance'. Therefore, having an 'emotional awareness' conveyed a sense of being 'good enough' as a nurse while not necessarily being highly interactive with the patient.

Patients' and relatives' experiences of nursing care was investigated by Attree (2001). The findings from this qualitative study of 34 acute medical patients and 7 relatives identified 'good' and 'not so good' care. Participants identified behaviours indicative of these two classifications of care. Patient care that was deemed to be 'not as good' was lacking in an adequate level of interaction and interpersonal aspects. That is, nurses who provided only limited communication and

information, spent little time with the patient, were distant and had little rapport, concern, and compassion, were more likely to be judged as providing 'not so good' quality care.

Nursing students' perceptions of a good nurse has been researched as far back as 1971. Friedman (1971) used a survey questionnaire to investigate differences in perceptions about 'a good staff nurse' between junior ($n = 48$) and senior ($n = 48$) nursing students. The results of the students were also compared with clinical instructors' responses ($n = 17$). Participants were asked to respond by indicating the characteristics considered very important for a good staff nurse. The senior students showed statistically significant lower regard for two characteristics, 'dedication' ($\chi^2 = 14.260$ 3 df, $p, < 0.01$) and 'good appearance' ($\chi^2 = 8.453$ 3 df, $p, < 0.05$). For the remaining seven items there was no significant difference in the two student groups. A limitation of the study is that the participants were asked to respond to nine characteristics in a forced choice study, with no explanation as to why these particular characteristics were chosen.

The views of patients and carers ($n = 96$) on what makes a good nurse were explored by Rush and Cook (2006) in the UK. The participants were people with learning or physical disabilities and their carers, with recruitment being undertaken from self help groups and schools. Interviews and focus groups were taped with 525 comments recorded on the topic of reflecting on their good and bad experiences of hospital or community care. The findings suggest three main requirements of a good nurse: attitudes (50%), skills (28%) and knowledge (22%). There were 102 comments about communication, and this was the area of most comment. This study did not focus on individual nurses who were thought to be good nurses, but rather the acts and behaviours of nurses who were thought to be good or not so. Some

responses were generalised, with a lack of clarity... ‘so they look as though they are interested, it’s not just going in their ears’ and ‘a lot of them don’t know the procedures, they don’t know if they should be doing something or if they are doing something wrong’ (Rush & Cook, 2006). Participation in the study was limited to people with physical and learning disabilities and their carers, therefore the findings of the study lack generalisability.

Descriptions of Outstanding Nurses

A limited number of research studies have been undertaken to examine the nature of the outstanding nurse. A study by Stiles (1990) found that there were five main themes when 11 hospice nurses and 12 families in bereavement were asked to describe the nurse-family spiritual relationship. These five themes were: nurses’ ways of being, nurses’ ways of doing, nurses’ ways of knowing, ways of receiving and giving, and ways of welcoming a stranger. These themes are confined to a specific aspect of the outstanding hospice nurse’s practice, and have yet to be investigated in the general registered nurse population.

Kendall (1999) interviewed oncology nurses to identify nurses who were more than good nurses. Twelve oncology nurses were interviewed using a semi structured interview format and asked to recall and describe outstanding oncology nurses with whom they had worked. Twenty one grouped themes were identified and each theme was categorised in terms previously identified by Stiles (1990). These included nurses’ ways of Being; Doing; Knowing; and Giving and Receiving. Kendall found that the outstanding oncology nurse “... is professional, committed and caring; delivers excellent nursing care, both basic and technical; is knowledgeable; has advanced communication skills and establishes strong

relationships with clients and peers”. The findings from this study form a useful framework and provide constructive information, but may be limited to the oncology nurse population. It would be useful to extend this type of study to other nurse populations such as general medical/surgical and mental health nurses.

Descriptions of Excellent Nurses

Danish breast cancer patients (n = 10) described excellent nurses as being competent, compassionate, courageous and concordant. In a descriptive explorative study to explore the essential characteristics of an excellent nurse conducted in Sweden (Jensen, Bäck-Pettersson & Segesten, 1996), ten Danish women being treated for breast cancer were interviewed to describe their experiences of the excellent nurse in the context of a caring situation in which the nurse was involved. An important aspect of the methodology of the study asked that the participants reflected on a specific nurse who they perceived to be an excellent. However, the study is limited, because the nurses being described were all from the oncology department. The findings speak well of oncology nurses caring for breast cancer patients, but they may not be able to be generalised to the wider community of nurses. A highlight of the study findings was that the patients took for granted that the nurse should be instrumentally competent, and they stressed the importance of expressive nursing competence. That is, it was considered to be an attribute of the excellent oncology nurse that the nurse was able to communicate effectively and compassionately when interacting with the patient.

Noble-Adams (2001) conducted a literature review to explore the phenomenon of “exemplary” nurses. Exemplary was defined by Noble-Adams as the ‘profession’s finest’ based on a number of criteria. Not only were these nurses

experts, but they also had other qualities which made them stand out. They derived their reward system internally such as the reward derived from striving to be the best possible nurse; rather than an external reward such as salary level. Noble-Adams explored the topic by conducting a literature search and selected journal articles that “...*began to illuminate the different facets of these ‘exemplary’ nurses*” (Noble-Adams, 2001, p. 24). She defined these different facets in her review as work excitement, positive energy, commitment, “perhaps” having a special calling, altruism and natural caring and personality. Many of the Noble- Adams’ resource material is not research based. The work of theorists is utilised to derive her conclusions eg. Jung, 1980; Paterson and Zderad, 1976; Parse, 1992; Peplau, 1952; Rogers, 1970 and Watson, 1979. Therefore much of what Noble-Adams reports is not research based and does not use specific examples of exemplary nurses from the field.

Expertise in Nursing

In the 1980s Patricia Benner conducted a seminal study to define nursing expertise. Her work identified five levels of proficiency in clinical nursing practice. These five levels were based on Dreyfus’ five stages of skill acquisition (Dreyfus & Dreyfus, 1986). The Dreyfus Model of Skill Acquisition was originally developed in research designed to study pilots’ performance in emergency situations. These five stages are; novice, advanced beginner, competent, proficient and expert. The model proposes that, in all cases where individuals acquire expertise, the learners go through five stages from novice to expert – people who do a skilled job effortlessly and fluidly, intuitively almost never make a mistake. Expertise develops in actual clinical situations through a process of comparing similar and dissimilar clinical

situations. Benner (1984) also suggests that perceptual awareness is central to good nursing judgement. While a beginner is mastering the organization, skills, and dexterity required to carry out tasks, the competent practitioner accomplishes a plan of care and is able to predict and control activities and plans related to the plan (Benner, 1982). At the expert level, the nurse no longer relies on rules and guidelines to connect understanding of a situation to an appropriate response (Benner, Tanner & Chesla, 1996; 1997).

Benner reports that the ‘...mundane moments...’ (Benner 1984, p xxii) were not captured in her research. The study investigated outstanding clinical situations to describe skilled decision making in critical situations. This approach therefore failed to demonstrate that outstanding nurses show exemplary behaviours and skills in all situations. They are in effect ‘on duty’ giving a skilled performance all of the time *through the hours of boredom and moments of terror* (emphasis mine).

Benner’s work is important and illuminating. Her study identified the level of discretionary judgement exercised by expert nurses in outstanding clinical situations. The study also demonstrated how the Dreyfus Model of Skill Acquisition applied to nursing can show the progression of expertise that can result from clinical experience. The informants’ narratives in Benner’s study were presented in a way that included content, action and context which was situated in their clinical experience. The research explored the meanings embedded in nursing practice, thereby establishing the benchmark for how further studies investigating meaning and knowledge in nursing practice might be undertaken. Benner used Behavioural Event Interviews as a means of identifying the 31 competencies of expert nurses. This involved the participants recounting a significant event and their role in it.

More recent studies have been undertaken to identify expert nursing practices. Brykczynski (1998) interviewed 11 expert staff nurses using Critical Incident Technique in an acute hospital in Texas, USA. The participants were interviewed by the researcher and transcripts analysed using interpretative phenomenology. Her study identified that some of the expert practices identified are not behaviours commonly identified as organisational expectations in performance appraisals for staff. The findings were analysed using Benner's (1984) previously identified domains of practice. In the 'organizational and work role competencies' the nurses competency was originally emphasised as meeting the patients needs and requests. The expert nurses in this study were seen as the hub of the unit; as the one who had the total view. This total view included not only patient care but also administration, staff capabilities and resources needed and available.

An Australian study examined the nurse patient relationship, concluding that nursing was imbued with what the researcher (Taylor, 1994) described as ordinariness. Ordinariness in nursing as described by Taylor refers to the sense of shared affinity that nurses and patients have for one another as humans. She defined nursing as that which happens between nurses and patients. Therefore, the nurse's extended role was not considered. However, the unique nurse patient relationship was described as being one which was facilitated by the interpersonal relationship between both parties. Taylor wrote about the ordinariness of nursing in terms of the relational abilities of the nurse and patient. In exploring the phenomena of ordinariness in nursing the 'voice' of the nurse participants was one that described everyday human qualities and clinical practice in nursing. It is important to raise Taylor's study here as not all first person accounts by nurses about nurses are spoken

with the voice of a hero narrating about actions during difficult moments or critical events. Some accounts narrate the everyday practice of nursing.

First person clinical practice narratives form the basis of professional self understanding and are now used as evidence for clinical nursing expertise. Nelson and McGillon (2004) argue that rather than clinical narratives revealing nursing practice, they may actually place the emphasis on the nurse as an individual actor, without the structural practice context. In addition, these narratives represent 'preferred accounts' of nursing, and, as such, add a cautionary consideration to the use of first person narratives "...to examine, explain and measure nursing competency and expertise..." (Nelson and McGillon, 2004, p. 633). Uncontested first person claims of expertise have been questioned by others (Allen, 1995; Meerabeau, 1992). Nelson and McGillon argue that Benner's technique to identify expert practice was highly orchestrated. They comment that aspects of her data collection amounted to narrative control. Nurses were "... coached and drilled on the acceptable expertise narrative". Nelson and McGillon made comparisons with three excerpts from personal statements submitted by practising nurses for the American Association of Critical Care Nurses excellence awards. They identified that two of the statements were focused on the affective response to human distress. The third excerpt focused on expertise in managing a difficult patient without enlightening the reader about the nurse's knowledge or what was done for the patient. The nurse in each statement is presented as a hero, but Nelson and McGillon assert that it is difficult to ascertain the expertise of the nurse in the personal statements. These statements are in contrast to Benner's participants who articulated well their expertise. The visibility of expertise in clinical practice is dependent in first person accounts on nurses being able to articulate expert practice well. Nelson and

McGillon suggest through their critique of Benner's method in her 1996 study, that the responses of Benner's participants may have been influenced by the level of coaching. Further, first person accounts produce a highly positive discourse about nursing practice and therefore have uncritically been used in research to increase the visibility of the nurse in clinical practice.

Personal Qualities and Characteristics of Nurses

The personalities and qualities of nurses are considered to be important for their interactions and relationships with patients and health personnel. Lewis and Cooper (1976) conducted a comprehensive review of studies investigating the personality characteristics of nurses. Most of the 66 studies reviewed involved nursing students, with only four studies involving registered nurses. Interpretation of the results was reportedly difficult because of the large number of different personality tests utilised, different methods, the differing samples and wide variations in the degrees of rigour applied. Most of the studies were descriptive or compared a nursing sample with a non-nursing sample. One finding from the review was that nurses needed a higher level of intellectual ability. However, higher intellectual ability did not necessarily ensure better nursing. The review did not identify characteristics of registered nurses, who might be considered successful as each study reviewed identified criteria for success differently. As this review took place over 20 years ago, this finding may not be relevant today, as aspects of nursing have changed, particularly in the area of technological advances. The review did not find personality tests to be particularly predictive of good nursing practice or success in nursing.

Lewis (1980) completed a more useful study using the 16 PF (The Sixteen Personality Factor Questionnaire). The participants were nursing students, newly qualified nurses, and successful nurses (as measured by promotion). The successful nurses were found to be “...*more intelligent, more conscientious and persevering, more imaginative and creative, but at the same time, socially aware and in control of their emotions, more emotionally mature and more experimenting...*” than the other nurses in the study. This study suggests that nurses in promotional positions may have certain attributes that enhance their opportunities for success, but whether the attributes were developmental in nature in the study were not recorded in the study. The characteristics identified are personality based and can be said to be the important attributes of the good ‘everyman’ or the good citizen, rather than being specific to a good nurse doing good nursing.

Sand (2003) explored the extent to which different personal qualities and personality factors, were represented in a group of assistant nurses (n = 51) in Sweden. The nursing related qualities were empathy, sensitivity to non-verbal communication, feelings of discomfort, indifferent nursing situations, and work satisfaction. This study however did not solicit responses from registered nurses and so the findings cannot be extended beyond assistant nurses.

Personal characteristics were investigated with registered nurse participants in a qualitative study to identify personal characteristics that contribute to effective nursing performance (Zhang et al, 2001). The researchers used the method developed by McBer and Company (Boyatzis, 1982; Klemp & McClelland, 1986; Spencer & Spencer, 1993) to identify competencies. Using the critical incident technique fifty nurses from Beijing were each asked to describe their behaviour in a successful incident and an unsuccessful incident. Each nurse was also asked to

describe the context of the incidents; that is, describe the situation which led to the incident, and to describe their thoughts and feelings at the time, and the result or outcome. The researchers devised a semi-structured questionnaire to elicit the information and asked the nurses to respond in writing. Interpersonal understanding, commitment, information gathering, thoroughness, persuasiveness, compassion, comforting, critical thinking, self control and responsiveness were the ...“top 10”... (of 47) important characteristics identified. The methodology used (critical incident) is a sound way of identifying competencies however, face-to -face interviews will enable more detailed information to be obtained about the more elusive, and often, difficult to identify, aspects of the nurses role. A further limitation of the study is that only senior nurses were asked to participate in the study, limiting its generalisability.

Competence

In any occupational group, competence is a crucial issue (Walker, 2005). Competence is also relevant to the profession’s organisation which sets the standards as well as governments and health care systems (Piercey, 1995). Adoption of competency standards enables professions to recognise and describe role, regulate practice, delineate specific functions of roles and plan career structures (Piercey, 1995). In nursing, competence encompasses more than just psychomotor skills (Benner, 1984). As mentioned in the previous section, nursing involves holistic care of emotional, social and cultural care as well as a person’s physical condition.

The community expects high quality nursing care to be delivered by individual nurse professionals who are competent. Systematic, high quality care requires that the clinician be appropriately skilled for the health issues the patient faces, since the competence of health professionals directly affects the quality of care received by the patient. Professional competence is considered to be context

dependent and evolving and changing (Atkinson, Jackson & Rawlin, 2007). The requirement that clinicians update their knowledge and skills to maintain competence is a crucial issue in any professional group. Therefore it is important that clinicians are actively engaged in maintaining and expanding their professional competence as the requirements related to their professional practice changes as the range of knowledge and health care practices change.

The Meaning of Competence

The literature is replete with definitions of nursing competence. There is a lack of consensus among researchers, and considerable ambiguity and contradiction in the various ways competence is used (Ashworth & Morrison, 1991; Bowden & Masters, 1993; Bradshaw, 1997; Bradshaw, 2000a; Dolan, 2003; Girot, 1993; McMullan et al., 2003; Milligan, 1998; Mustard, 2002; Watson et al., 2002; While, 1994). In particular, the words competence and competency are often confused, used inconsistently and interchangeably, and made unclear when discussed or defined in relation to nursing. These are examined in some detail below in the context of guidance provided by While (1994) and the ANMC Inc. (2006), who argue that there are registered nurses currently practising who do not meet the current stated conceptualisations of nursing competence.

Benner (1982) and Nagelsmith (1995) defined nursing competence as the ability to perform a task with desirable outcomes under the varied circumstances of the real world. Chapman (1999) extended their definition by contending that competence is “ ... being more concerned with what people can do, rather than with what they know ...” so nurses could be said to focus on ‘doing’ rather than ‘knowing’. Pearson, Fitzgerald, Walsh and Borbassi (2002) suggest that the term competence has no singular definable meaning and that it is believed generally to not

be directly observable, but rather describes a set of characteristics or attributes that enable competent performance. Competence has also been described as being more than the performance of skills, it is the intuitive grasp of care situations underpinned by deep understanding and experience (Benner, 1984; Redfern, Norman, Calman, Watson, R., & Murrells, 2002).

In the nursing literature it is not made clear whether competence is considered a personal construct, which is then brought to nursing, and enhances the practice of nursing, or whether it is derived from the education process and practice of nursing itself. Specific competency statements usually convey information about what nurses should do in their jobs, without implying that the nurses are competent to do something beyond that specified. McMullan et al., (2003) are among those who note that the terms competence, competency, and performance are still used inconsistently and interchangeably, especially in describing performance as job related, and a description of action, behaviour or outcome of performance.

Three approaches to competence have been described in the literature (While, 1994). These approaches are described as behaviourist, generic and holistic, as described below.

Behaviourist concept of competence

A narrow concept of competence can be conceived as the discrete behaviours associated with the completion of a single task. In effect, the task becomes the competency.

Generic concept of competence

A more generic explanation of competency can be found in the psychological and management literature (Boyatzis, 1982; McClelland, 1973). This interpretation concentrates on the general abilities of the superior or effective practitioner's role

performance, which may be transferable to other roles and is claimed to predict occupational success. General abilities or attributes in this more generic explanation of competence are said to be predictive of occupational success; that is, they allow differentiation between superior and average job performers. This model tends to ignore the context in which the competency takes place. Instead, the personal attributes are described, while limited or no attention is given to the context – the situation, resources and constraints. Therefore, the notion that expertise is domain specific is ignored (Benner, 1984). Expertise in one domain is therefore no guarantee of expertise in others. For example, an experienced intensive care nurse is not necessarily also an expert in geriatric nursing. The level of previous expertise practised in one environment may not be observed or demonstrated in another environment.

Integrated or holistic concept of competence

A third approach (Gonzci, 1994; While, 1994) is referred to as an integrated, holistic, or relational approach. This perspective of competence joins both the above interpretations and considers the context in which the professional works. That is, the general attributes are married to the context in which they are employed. This perspective allows for the incorporation of values, the need for reflective practice and ethics, and reflection of the knowledge, attitudes, values and skills associated with each aspect of workplace performance, as expressed in professional practice. The Australian Nursing and Midwifery Council Inc. (ANMC, 2009) provides a definition which states that competence is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession which encompasses confidence and capability.

Competence in the Australian Context

The competency-based movement in Australia has reflected developments in other Westernised countries such as the USA, Canada, New Zealand and Great Britain. Over the past 20 years the competency movement for professional nursing has been gathering momentum. This development has, in part, come about to improve consistency in workforce training and accreditation, and has fostered the portability of qualifications both nationally and internationally (Nelson & Purkis, 2004).

“The term competence focuses attention on outcomes. It is about what people can do” (Mayer Report, 1992, p. 4).

The Mayer Report (1992) from Australia condensed the findings of the earlier Australian Finn Report, in defining competence. It was the opinion of the committee that a broad definition of competence recognised that performance is not only underpinned by skill, but also knowledge and understanding. Competence involves both the ability to perform in a given context, and the capacity to transfer knowledge and skills to new tasks and situations. The committee further stated that competencies are transferable and are not automated ‘trained’ behaviours. They are mindful, thoughtful capabilities, and cannot be explained by low level drill and reinforcement. Competence requires the capacity to think about performance and also to perform. The competent performer has grasped the principles behind actions, thereby enabling the possibility of transferability to new contexts. Distinctions need to be made between key competencies and generic competencies.

In Australia, the National Office of Overseas Skills Recognition (NOOSR) established a number of initiatives to review the education and assessment of the professions (Gonczi, Hager & Oliver, 1990; Masters & McCurry, 1990; National

Office of Overseas Skills Recognition, 1995). The definitions identified in the reports for competence and related terminology included,

*“...Competence: A construct referring to all the personal characteristics that together enable competent performance...Competency: The ability to perform the activities within an occupation or function to the standard expected in employment ...Competency standards: Levels of achievement required for competence in key areas of professional practice..., Attributes: The knowledge, abilities, skills and attitudes that together underlie competent professional performance..., Attitudes: Personal qualities or dispositions, such as patience, persistence and compassion, which are important in successful performance of some professional tasks...”*National Office of Overseas Skills Recognition, 1995 p.67).

The emphasis has been placed on the term competencies, and the related standards are what are examined by nursing regulatory bodies when nurses present for initial registration. A competent professional therefore has the attributes necessary for job performance to the appropriate standard. The key elements of competence are attributes, performance and standards (Gonczi, Hager & Oliver, 1990). The outcome of meeting the competencies is that the nurse is deemed competent to practise as a registered nurse. The ANMC Inc. (2006) has developed national competency standards to describe the functioning of the registered nurse on entry to practice. These consist of the four domains: Professional Practice, Critical Thinking and Analysis, Provision and Coordination of Care and Collaborative and Therapeutic Practice. These domains act as a framework on which to build curricula and regulate the profession. The ANMC has further defined some key terms

“Attributes: Characteristics which underpin competent performance... Competence: The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area...Competency Standards: Consists of competency units and competency elements...”(ANMC, National Competency Standards for the Registered Nurse, 2006).

Barratt-Pugh (1995) argues that the search for excellence is devalued by only promoting competence. This is argued on the basis that learning is restricted to stated outcomes and therefore encourages reproduction rather than creativity. The emphasis is all about skills and practical application, without conceptual and theoretical background, which makes it only applicable to lower order skills such as cognitive and psychomotor domains.

Only a quarter of nurses' competence levels are measured when there is a focus on skills and not knowledge using current methods of assessing competence (Santy & Mackintosh, 2000; Sharp, Wilcock, Sharp, & MacDonald, 1995). A number of authors (Chapman, 1999; McAllister, 1998) have raised doubts as to whether competency standards are appropriate for nursing. They suggest that competency standards focus on outcome orientated technical procedures and potentially are reductionist and positivist. They further suggest that such humanistic aspects such as empathy and attentive listening may become de-emphasised because of the ease with which we can measure more technical aspects of nursing. Watson et al., (2002) adds additional concern by stating that the drive for competence may lead to nurses being educated to meet merely the minimum standards.

Continuing Competence in Nursing

During the 1980s, the Australian federal government began the process of reforming the economy through workplace reform (Purkis & Nelson, 2005). As a result of the reports Australia Reconstructed (1987) and the Finn Report (1991) a number of 'key competencies' were developed with the aim of ensuring consistency across entry levels of training and education (Pearson, Fitzgerald & Walsh, 2002). The general benefits when having competency requirements were seen to include consistent recognition across States and Territories; accreditation by all States and

Territories for applicants who meet the standards, whether trained in Australia or overseas; a transparent assessment of those with overseas education and work experience against agreed standards of performance, articulated training and progression within industries, and recognized articulations with related occupations (Heywood, Gonzci & Hager, 1992). A good set of competency standards, according to Heywood et al., (1992) provides a clear statement of what is considered to be important in competent *performance* (italics mine) in that profession.

A subsequent Australian report (the Mayer Report) produced a list of seven key competencies which were designed to identify a focus for education and industry and reflect notions of 'best practice'. Each profession would thereby achieve the goal of standardizing their educational processes and achieve portability of educational qualifications, which would, in turn, produce a more efficient workforce. The Australian Nurse Registering Authorities Conference (ANRAC) began the process of developing nursing competencies in 1986.

Nursing's engagement with the competency based movement also had enthusiastic supporters overseas. Benner's work in the 1980s had international impact. Generally, there has been wide acceptance for competencies within the profession at various levels. These include nurses, employers, registering authorities and educators. Competencies have been seen by these groups as a framework for curricula, legislation, professional development, and assessing continuing safety to practise (Purkis & Nelson, 2005). Competence, as Purkis and Nelson (2005) suggest, has emerged as the favoured way of making determinations about the ability of nurses to fulfil their role within society.

In 1997 the Australian Nursing Council Inc. commenced work on a project to identify the indicators of continuing competence in nursing. At that time, the

majority of nurse regulatory authorities in Australia had either legislative provision or policies which required nurses to have practised within the previous five years in order to renew their registration. These legislative provisions and policies were based on the unproven assumption that recent practice indicated competence to practise. The research project was undertaken by a consultancy team headed from the University of Adelaide (Pearson, Fitzgerald, Walsh & Borbasi, 2002) and involved national consultation with key stakeholders. A random nursing survey followed to determine which of the options derived from the preceding rounds of consultation should be implemented as a measure in determining ongoing competency. A 'Continuing Competence Framework' (ANMC, 2009) has now been developed and sets the standard and guidelines by which registered nurses' continuing competence is assessed and evaluated by the Nurses and Midwives Board for the purposes of ongoing registration and therefore the right to continue to practise as a registered nurse. However, each health care facility develops its own performance appraisal tool and methods to determine the level of workplace performance achieved by the individual registered nurse. Therefore role performance as assessed by the employer and meeting the competency standards as described by the ANMC may create variable outcomes in practices if different agencies use dissimilar criteria. Competencies for Advanced Nursing Practice have also been developed (ANMC, 2005) to guide the extension of the nursing role to an advanced level (McMillan, Andrews & Bujack, 1996).

Clinical Competency Education for Nurses

The education of nurses in the UK and Australia is evolving and educators are currently grappling with how best to educate the nurses of the future (Bradshaw, 2000). A number of factors have made nursing education a critical issue. It is well

known that there is a world wide shortage of registered nurses (ICN, 2004). To address this shortage governments in Australia have increased the number of funded places for registered nurse education at universities and enrolled nurse education at Institutions of Technical and Further Education (TAFE). Working conditions have also changed in response to the shortages, with nurses having to work in conditions of staff shortages on the wards, and differing skill mix. Whereas in the past, managers could choose staff levels according to their needs, in conditions of staff shortages, they must often relegate patient care to a combination of available Registered Nurses, Enrolled Nurses, and patient care assistants (or unlicensed personnel).

Nursing education has also undergone paradigm shifts in a number of ways. Firstly, the move from hospital based or service based education to universities. Prior to the 1980's the majority of nursing students in the UK and Australia were prepared for practice through the apprenticeship system initially developed by Florence Nightingale (Bradshaw, 2000a; 2000b; Watkins, 2000). Secondly, there has been a change from the structure and process based system where students needed to undertake their clinical component of the program in preset areas for specific time frames (eg two weeks in surgical and then two weeks in medical), to a competency-based system. This change includes a shift to outcomes based curricula. The competency-based system defines the desired outcome, such as competency in the nursing care of the acute medical patient, and an appropriate assessment tool is developed to measure competence. The greater challenge is to address the education, practice and evaluation of nurses' cognitive skills, attitudes and values.

Hearn, Close, Smith and Southey (1996) have previously identified that there are two subsets of competencies. The first are technical competencies that are unique

to each profession. The second are non-technical competencies, which are essential for application of the technical competencies. The generic and non technical competencies are *the real challenge* so that all nurses may have the opportunity to develop individual competence and integrate that into their own nursing practice and professional performance as nurses.

Role Performance

A competency has an intent, and an action, which then leads to job or role performance (Spencer & Spencer, 1993). The distinction between competence and performance has been described by Messick (1984). Competence is what a person knows and can do under ideal circumstances, while performance is actual situated behaviour, that is, what is done in the real-life context. Coleman and Borman (2000) have identified job performance as being able to be classified as either task or contextual performance. Task performance is defined as those behaviours that contribute directly to “the organisation’s technical core”, behaviours that are delineated according to role requirements (Greenslade & Jimmieson, 2007, p. 603). Contextual performance refers to behaviours that maintain the social context. These behaviours have been identified by various researchers as providing organisational support or behaviours that help the hospital to function, job-task support (Coleman & Borman, 2000) and interpersonal support (Kidder, 2002). These include activities such as helping co-workers (Coleman & Borman, 2000). Biro, Waldenström, Brown and Pannifex (2003) and Waldenström, Brown, McLachlan, Forster and Brennecke, (2000) report on a randomized control trial with midwives as participants which found that patient satisfaction with nursing care is higher when nurses engage in contextual care such as working together to provide continuity of care. This suggests

that patient satisfaction increases when the nursing focus is on contextual performance.

How a nurse behaves in a given situation, depends on the role that she/he sees her/him self playing in the particular work setting (Allen, Frasure-Smith & Gottlieb, 1982). Zhang et al., (2001) state that superior performance requires a range of underlying competencies, including attributes and personal characteristics. This combination helps to translate skills and knowledge into effective action that leads to excellent performance. The performance of nurses in a hospital setting is fundamental to the delivery of quality patient care and good patient outcomes and has a significant impact on patients' physical and psychological health during hospitalisation as well as post discharge (Lee, Chang, Pearson, Kahn, & Rubenstein, 1999).

The expression of individual nurses' values occurs within the perspective of nursing as an art (Fagermoen, 1997). Therefore, meaningful nursing practice can be seen as developing from the expression of self through actions and interactions with patients and collaboration with others. Patients expect that the care they receive will be appropriate, effective in leading to expected outcomes and of a high quality. However, McGaghie (1991) suggests that there are many intermediaries to high quality performance. These include; honesty, judgement, work habits, maturity, adaptive capacities; low motivation and fatigue, and circadian rhythms.

Beyond Competence

Beyond Competence - The Limits of Competence

According to Barnett (1997) the two leading ideas about competence are academic and operational, and these reflect the narrow worlds of work and academia. Cowan, Norman and Coopamah (2005) have previously noted that the need to ease

the tension between these two spheres of influence arose following the move of nursing education to higher education. However, there continues to be little consensus in nursing about the appropriate definition of competence, with some academics believing that competency based assessment is invalid, unreliable and capable of only dealing with the superficial aspects of practice.

Chiarella, Thoms, Lau, & McInnes, (2008) indicate that competence has been identified in different ways. Competence has been identified by some academics and researchers as a behavioural objective (Chapman, 1999; Eraut, 1998; Girot, 1993; Winskill, 2000); perceived as a performance (While, 1994) and as a psychological construct, which includes cognitive and less easily measureable affective skills (Chapman, 1999; McAllister, 1998). In addition, distinguishing between different levels of competence has been identified as problematic when assessing clinical skills (Girot, 2000). Chiarella et al., (2008) have identified that challenges remain within the nursing profession with regard to competency standards, especially the inability of the students to reflect the complexity of nursing care. Describing care in terms of minimum standards has led to the description of competency-based education as reductionist (Goldsmith, 1999; McAllister, 1998).

Competency is the essential underlying component of being capable. However, there is increasing agreement that competence and competency assessment deal with predictable situations (Chiarella et al, 2008; Gardner, Hase, Gardner, Dunn & Carryer, 2008). As noted by Gardner et al., (2008), demonstration of competence is not sufficient to enable people to take actions which are effective and appropriate. Increasingly, questions are being raised about the adequacy of concentrating on competence in preparing nurses to respond effectively to the complexity of nursing in contemporary health care environments.

Beyond Competence - Complexity and Capability

"I think the next century will be the century of complexity." (Stephen Hawkins, 23rd January 2000, cited www.comdig.com).

This section of the chapter aims to introduce complexity theory and review the relevant emerging health science and nursing literature on nursing complexity and capability. This thesis is not about complexity at the organisational level, nor does it address the nursing unit organizational structure. Its focus is on the nurses who must function in health care systems, which are increasingly complex.

Sturmberg and Martin (2009) suggest that complexity can be understood in two ways: firstly, in the sense of the complex multifaceted unpredictable world in which we live, or/and secondly in the epistemological sense of complex science and theories. Complexity theory is concerned with complex systems and their behaviour over time. A comparison of complexity science and established science is provided by Matlow, Wright, Zimmerman, Thomson and Valente (2006) where complexity science is described as being about holism, indeterminism, relationships among entities, a focus on variation whereas established science is about reductionism, linear relationships and focuses on means or averages. The reductionist approach to solving problems where bigger problems can be broken down into the constituent smaller parts, analysed and solved by deduction may no longer work when systems and organisations are complex and changing. Relationships such as cause and effect are no longer clear cut and linear but more likely to be an interplay of factors and non linear. According to Hase (2002) there has been a shift in recent times away from rationalism and reductionism to a more humanistic approach to management and in particular, people management. Hase (2002), in an organisational case study where the level of self - efficacy amongst the staff was high, suggested that self-

efficacy may be an integral factor in helping people deal with uncertainty. He suggests a need for future research to combine individual and organisational variables to provide insight into how best to deal with a rapidly changing and complex environment.

The health care system is one system that has become increasingly complex. This complexity has increased across all health care disciplines. Plesk and Greenhalgh (2001) suggest that the current world view of “reduce and resolve” approaches to clinical care and service organisation needs to be replaced by new frameworks that incorporate a world view which is dynamic, creative and intuitive.

Many of the patients within our health care system are complex. They are increasingly likely to be patients with multiple health problems who require complex nursing care, multidisciplinary care and coordination of numerous services. Health care systems themselves are seen to be increasingly complex and are often described in the literature as complex adaptative systems. Brown (2003) has described complex adaptive systems as involving large numbers of parts undergoing an array of simultaneous non-linear interactions, with the impact of these complex systems being centred on the behaviour of the whole. Complexity science applied to health care focuses on the pattern as well as the networks and social context of patients, and emphasizes the importance of context. Healthcare takes place within a complex network of health care providers with a varying skill mix who may not necessarily agree what the outputs should be. Chafee and McNeill (2007) suggest that nurse clinicians may find complexity science useful in planning sophisticated nursing care in an unstable environment.

Capability

Capability is described by Hase as an holistic attribute “ ... comprised of creativity, high self efficacy, appropriate social and communication skills, the ability to work well in a team, knowledge of how to learn, and the ability to apply competencies in common and novel ways” (2000, p. 1). Capable people are more likely to be able to deal effectively with change and chaotic environments by possessing what Hase describes as an 'all round' capacity'. In addition, Hasse and Kenyon (2000) state that capable people are more likely to be able to manage continual change. When the health care environment is predictable, smart people can work well, but when the health care environment is unpredictable, there is a need for health care providers who are adaptable and able to be flexible in response to environmental changes and uncertainty.

Within a health care setting capability is described by a number of writers. Fraser and Greenhalgh (2001) describe capability as the extent to which individuals can apply, adapt and synthesise new knowledge in different service contexts. Capable people are more likely to be able to deal with complex environments because they tend to have characteristics such as self-efficacy, knowing how to learn, creativity, the ability to use competencies in novel as well as familiar situations (Hase & Davis, 1999a). Capable people also possess appropriate values and work well with others (Hase & Tay, 2004). Competence measures previous performance, whereas capability focuses on human potential and what performance might be in the future (Hase & Davis, 1999b). We now particularly need nurses who are capable of dealing with the unpredictable nature of complex environments.

There is an emergent body of literature in nursing exploring capability. Gardner et al., (2008) conducted research using qualitative methodology and

secondary analysis to investigate whether the components of capability adequately describe the attributes of nurse practitioners (NPs) in clinical practice using capability as a framework. The five attributes identified by Hase and Davis (1999b) were used to structure the data analysis. The interview material from a previous study (Gardner, Carryer, Gardner & Dunn, 2006) of fifteen NPs working in Australia and New Zealand was analysed. The findings suggest that both competence and capability need to be considered to understand the complex role of nurse practitioners. This study did not identify whether capability was limited only to nurse practitioners and therefore the findings are limited to this group of nurses. Some or all attributes of capability may be well evident in some nurses at a much earlier stage in their nursing careers.

Summary

This literature review has provided a rationale for the study based on previous research. Efforts to identify the characteristics and attributes of good nurses have, in the main, been centred on studies involving qualitative methodologies. A few studies have used a repertory grid methodology to identify the attributes of good and bad nurses. This has narrowed the attributes to those which are psychological or emotional in nature and so far have not identified all dimensions of good and outstanding nurses. The attributes of the outstanding nurse have only been described in conceptual or thematic terms as far as they relate to nurses working in the specific areas of oncology and palliative care. Considerable research has been focused on competence – little is known how capabilities develop, or whether nurses do, in fact, strive for excellence. Some studies have included patients and family members as participants in the studies. Few studies have addressed patients' perspectives of nursing practice, other than their satisfaction with care. No attention has been paid to

including other health care professionals, although the importance of nurse –health professional relationships was identified by Coulon and colleagues (1996) in their study investigating nursing excellence. A study of this nature is timely as the role of the nurse is a multifaceted one. The role dimensions of a nurse include professional practice, critical thinking and analysis, provision and coordination of care and collaborative and therapeutic practice (ANMC, 2006). Nurses collaborate with other professionals in the care of patients and therefore including other professionals in a study of this type will provide new insights into identifying attributes of nurses which are required in a collaborative and collegiate work environment.

Framing the Study

The study is conceptualised within a capabilities approach to human development. This approach was identified by Sen, an economist who defined a capability as “a person’s ability to do valuable acts or reach valuable states of being” (Sen 1993, p.30) and therefore it represents the combinations of both being and doing. Capabilities are opportunities to achieve what on reflection, an individual considers valuable. In the professional world it has come to mean that a capability is an underlying characteristic of a person which results in effective or superior performance in the job (Tracey, 1998; cited People Capability Framework Report, 2009, p.9) or better said, in the world of work. A capability reflects what a person could do given the freedom to achieve. As well as the opportunity to achieve the person must possess the agency to achieve. Agency, from this perspective, means self-agency; that is, the ability to take action. The opposite of having self agency is being forced, oppressed or passive. For capabilities to develop a person needs opportunities to develop, and also, importantly, the person needs to take personal

responsibility to achieve. In nursing, the capability approach extends the concept of competence to include the ability to apply the necessary knowledge, skills and attitudes to a range of complex and changing settings (Lindley, O'Halloran, & Juriansz, 2001).

The development of capability can be illustrated in a spiral. The notion of a spiral as a symbol of human development had its genesis in the work of Graves (1970; 1974). He proposed that human beings exist at different levels of existence. At any given level, an individual exhibits the behaviour and values characteristic of people at that level. In the current study participants were not asked to comment on specific aspects of values or behaviours of individual nurses. Instead they were asked to explain their perceptions of the evident differences between nurses who they believed were practising at the satisfactory, good and outstanding level. Within the theory of Spiral Dynamics their perceptions would be indicative of variability in the nurses' underlying personal capability, and their self-agency to achieve a certain level of practice beyond the competencies required of a registered nurse. The visible actions and reactions of the nurses under study would also be shaped by the contexts and complexities of their practice settings that may have contributed to their knowledge, skills and attitudes.

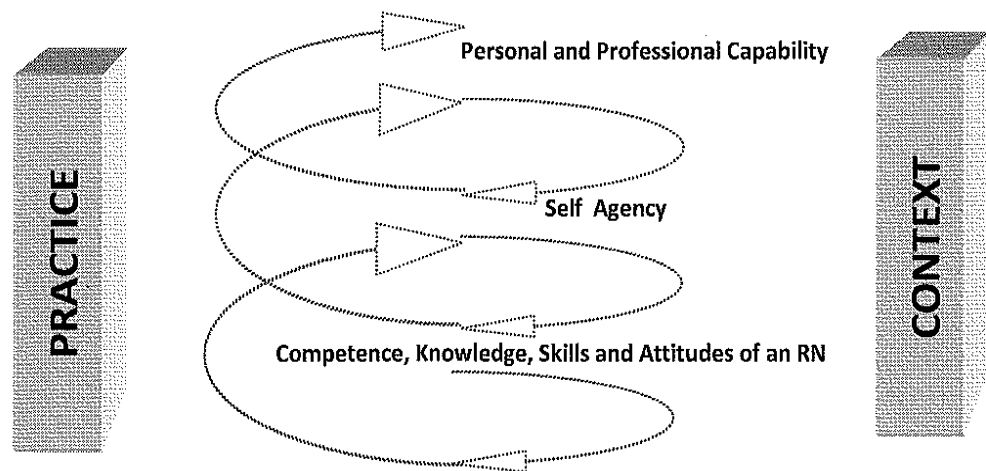


Figure 2.1 Spiral of nursing capabilities development

This study was not conceived to test the theory of Spiral Dynamics, but it uses the notion of a spiral to illustrate the progression of registered nurses in the development of his/her professional practice in a non linear fashion (see fig. 2.1). Not all nurses need enter their professional life at the level of a satisfactory nurse as some will have arrived into the profession with the capabilities to perform at a higher level, and therefore enter the professional development ‘spiral’ at a higher level.

This study was not seeking to examine the nature or extent of progression, but it was interesting to examine the findings through this capabilities development approach. It is possible that when nurses enter clinical practice some stay at the level of original competence, while others develop self-agency and higher order levels of capability in the context of practice.

“There is a need to move beyond training to harnessing ecological learning in order to develop human capability, as well as competence.” (Hase, 2000 p.1).

Chapter three will focus on the research methodology and methods used to answer the research questions and meet the overall aim of the study. The rationale for the selection of research methods used in the study will be explained. The steps taken to collect and analyse data will be outlined. Ethical aspects and issues of reliability and validity will be discussed.

CHAPTER THREE

METHODOLOGY

Section One - The Research Paradigm

Introduction

The purpose of this study was to explore perceptions of satisfactory, good and outstanding nurses from the perspective of a number of stakeholders using an interpretive qualitative methodology. Patton (2002) describes the mix of creativity and rigour behind the high quality of successful qualitative inquiry and the strength of the resultant data generated as follows:

The quality of qualitative data depends to a great extent on the methodological skill, sensitivity, and integrity of the researcher, Systematic and rigorous observation involves far more than just being present and looking around. Skilful interviewing involves much more than just asking questions. Content analysis requires considerably more than just reading to see what's there. Generating useful and credible qualitative findings through observation, interviewing, and content analysis requires discipline, knowledge, training, practice, creativity, and hard work.

(Patton, 2002, p. 5)

This study sought to provide a greater understanding of the nurses' practice by developing data from a number of participants with different roles within the health care sector who interact with registered nurses. This chapter describes the methodology of this study and outlines the procedural steps used to collect and analyse the interview data. Methodology in this thesis is taken to mean the philosophy underlying the procedures, and principles of the study which guide the strategies for data collection and analysis. The method explains how data collection and analysis were undertaken. The chapter is divided into two sections outlining the research paradigm and the methods. Ethical aspects are discussed, as well as the

strategies taken to ensure that claims can be made for confirmability of the findings and rigour of the analysis. This qualitative work provided a depth of understanding which would have been impossible through the presentation of only quantitative data.

For this study, it was important to identify an inquiry paradigm and a research framework that provided a way of accessing and describing the participants' experiences. It was intended to privilege the voices of the participants while recognising my human presence as the investigator and my role as the instrument for data collection and interpretation.

My critique of the literature about satisfactory, good and outstanding registered nurses and the associated areas of competence, expert practice and professional performance in chapter two indicated that there remains a great deal of misunderstanding over how attributes related to performance are usefully and consistently identified. I began this research with the assumption that registered nurses who performed in a professional and highly competent manner would be known to their colleagues, and therefore identified primarily by their knowledge about nursing and their clinical skills. However, engaging with the literature and my own findings has reframed my impressions of competence and performance of registered nurses as a more complex and multidimensional phenomenon that needs to be researched from the perspectives of different informants to illuminate its characteristics.

My assumptions about the Study

This study has arisen from five underlying assumptions:

- The registered nurse's role within the acute care setting is broader and more complex than only providing bedside care to patients.
- Aspects of nurses' work are often not seen, and therefore not clearly identified; for example, clinical decision making.
- Nurses work collaboratively with other health care team members. These health care team members will have an impact on role expression of the registered nurse, which has not previously been fully described.
- Different levels of performance by registered nurses are visible and known.
- There are discernible identifiable differences between good and outstanding nurses.

Research Paradigm and Philosophical Underpinnings

Paradigms specify the basic assumptions and beliefs about the nature of reality (Kuhn, 1996). Guba (1990) suggests that there are many paradigms used to guide our actions. He illustrates this point through examples of the adversarial paradigm that guides the legal system and religious paradigms that guide spiritual and moral life. How we know what we know will always be interpreted from within a philosophical basis or belief system that provides a framework. Kuhn (1996) suggests that we live in a changing reality. Kuhn's work outlined the view that each scientific discipline has its own way of framing inquiry and therefore generating its body of knowledge; that is, its paradigm. Nursing has identified two paradigms by

which nurses may carry out their practice, the human-environment totality paradigm and the human-environment simultaneity paradigm (Parse, 1987). The first paradigm, the totality paradigm views the human being as the sum or total of biological, psychological, sociological and spiritual parts. The simultaneity paradigm views humans as irreducible wholes, being more than and different from the sum of parts.

Research paradigms provide a means of generating knowledge, guide how the researcher undertakes and views the research. They also refer to frameworks within which research is conducted (Higgs & Titchen, 1995; Higgs & Titchen, 1998). The paradigm will influence what issues are worthy of inquiry and what approaches will be used to undertake the research. The paradigms that guide *disciplined inquiry* (emphasis mine) according to Guba (1990) can be characterised by three concepts and related questions. These three concepts and questions are firstly, the ontological question ‘What is the nature of the knowable?’ or ‘What is the nature of reality?’ The second question posed is the epistemological question ‘What is the nature of the relationship between the knower and the known?’ Third is the methodological question, ‘How should the inquirer go about finding out knowledge?’ (Denzin & Lincoln, 2000; Schneider, Whitehead & Elliott, 2007).

The ontological question asks what is the form and nature of reality, and what can be known about it. Ontology is said to differentiate between what really exists and that which appears to exist but does not (Bullock & Trombley, 1999). The epistemological question asks what is the nature of the relationship between the researcher and what can be known (Benner, 1994). The methodological questions ask how the researcher should go about gathering knowledge to answer the research question(s).

Research paradigms are therefore sets of beliefs and practices shared by researchers which regulate inquiry within disciplines (Weaver & Olson, 2006), and guide the action of the researcher. Three competing paradigms were described by Kuhn: empiric-analytic (positivism), hermeneutic (interpretive), and critical theory (Kuhn, 1996).

Higgs (2001) took a similar approach and distinguished between three core research paradigms and added an additional paradigm. Higgs' framework includes the following four paradigms: these are the empirico-analytical paradigm; the interpretive paradigm; the critical paradigm; and the creative arts paradigm. The paradigm approach and Crotty's (1998) epistemological approach are comparable in that the progress of the research inquiry process is one where one aspect builds on another.

Interpretive Paradigm

Of relevance to this study, the interpretive paradigm differs ontologically from positivist, postpositivist and critical theory because it is based on relativism. This view of 'truth' holds that there are multiple realities. It differs from the other paradigms of positivism, postpositivism and critical theory, which are based on realism, or the notion that knowledge and meaning exist objectively in the world independent of human concerns, and await discovery (Weaver & Olson, 2006). The interpretive paradigm reflects recognition that meaning is a human construction. Therefore, the research goals are to understand, interpret, seek meaning and illuminate (Higgs, 2001).

Interpretation

Interpretive research is a subjective practice. The researcher brings to the data collection, analysis and report writing something of themselves. So, it cannot be said

that the researcher undertakes the study as a *tabula rasa* – a clean slate. Woolcott (1994), explains interpretation as being derived from our efforts of sense making, which is a human activity involving intuition, past experience, emotion and personal attributes of the researcher. Interpretation in his view, invites examination and “pondering” of data *in terms of what people make of it*. It is a humanistic endeavour wherein ‘reflexivity’ during the researcher’s engagement with the data helps ensure accurate interpretations of participants’ multiple realities.

Interpretivist researchers consider that social reality is a matter of the subjective interpretations by social actors, including researchers. Interpretive approaches aim to describe, explore and generate meaning within a social or practice context (Schneider et al., 2007). Understanding meaning in the social sciences therefore requires that the researcher interprets or understands the meaning of human action in the natural context (Finlayson, 2005). Lincoln and Guba (1985) argue that any event under investigation will always take as much meaning from its context as it does from itself; that is, how reality is constructed, cannot be separated from the environment within which it is experienced. Therefore, reality constructions are time and context dependent (Guba & Lincoln, 1981, 1989; Lincoln & Guba, 1985). The assumptions of the interpretive paradigm are radically different to the empirico-analytical paradigm. For example, Streubert and Carpenter (1995) identify some key interpretivist assumptions that include:

- Multiple constructed interpretations of reality. However, Guba and Lincoln (1981) more clearly put forward that it is the interrelatedness of multiple realities that form patterns of ‘truth’, and it is these patterns that research seeks to understand, rather than any notion that a single truth exists.

- The researcher and research participant are in an interactive relationship. The research is not conducted in a detached way with the researcher observing without being involved as is in the empirico-analytic paradigm. Findings shaped by multiple realities emerge as the research proceeds, through interpretation between the researcher and the research participants. Therefore the researcher and the participants are mutually influential.
- Description and understanding can be more useful than establishing cause and effect relationships.
- Inquiry is value bounded. It is not possible for research to be value free. All research findings are affected by the values, previous experiences and theories that researchers bring to the research process.

My study was guided by the interpretive paradigm using naturalistic inquiry. I adopted the interpretive paradigm as the guiding framework for the study because it was congruent with the aims of the study, which intended to identify understandings and meanings by accessing and describing the experiences of study participants in relation to outstanding, good and satisfactory nurses. My interpretive approach focused on the understandings and meanings of the participants and sought to describe and illuminate the reality of nursing practice as socially constructed and naturalistic.

There is often confusion around the meaning of research terms in naturalistic research. This is reflected in the multiple terms used to describe naturalistic research. These terms include postpositivist, subjective, phenomenological, naturalistic paradigm, qualitative and humanistic. Lincoln and Guba (1985) suggest that the

ambiguity exists because researchers who engage in this type of research take different perspectives about what it implies. The two tenets of naturalistic methodology are that the research is undertaken in the natural setting; that is, phenomena are investigated as they occur naturally, and secondly, that research outcomes are derived inductively (Jenks, 1993). The research takes place in real-world settings, that is, in the context or setting where the key participants act and interact, and the researcher does not attempt to manipulate the phenomenon of interest as would occur in the laboratory setting (Patton, 2002).

An appropriate research method is imperative in attempting to address any research question. My study was about exploring the perceptions of the stakeholders and therefore it invited a qualitative design that would allow exploration and interpretation of the social world. The data collection method used for this study was in-depth individual interviewing. This allowed me in the role of researcher to engage with participants and conduct an analysis of data that emerged from familiarity with the participants to gain a sense of the meanings which people gave to their experiences. The qualitative approach enabled me to share in the participants' experience, to listen, question, hear and interpret the significance of their experiences. The expected outcome of this type of qualitative interpretive research was to discover insights, rather than simply to verify pre-existing ideas (Denzin & Lincoln, 1994).

Critical Incident and the Everyday

The term critical incident seems to have come originally from biography where it refers to some event or situation that marked a significant turning point or change in the life of the subject (Miles & Huberman, 1999). In biographical accounts

of critical events, Tripp (1994) suggests that critical incidents are not only fragments and minute samples of what actually occurred but are also emotionally charged and uncorroborated. It therefore makes sense to include fairly ‘trivial’ incidents or the commonplace events in biographical accounts. Tripp (1994) was referring to the commonplace in the life of the classroom teacher, but critical incidents occur in other professional contexts, including the everyday life of the ward nurse.

Benner was one of the first nurse researchers to use the critical incident technique as a method of gaining completeness of data from nurses’ accounts of their practice (Benner, 1984). By embedding their description in critical incidents her research participants were able to provide comprehensive descriptions of clinical nurses practising at various levels of knowledge and skill development. Benner’s research (1984; 1994; 1996) has focused on critical incidents as a technique. The critical incident has a boundary of a beginning and an end and therefore does not convey any information about how a person behaves outside the boundaries of a critical event. I sought to include both critical incidents and the everyday moments in my study as a way of capturing a more comprehensive description of nurses.

The ‘Voice’ in This Thesis

Rosanna Hertz (1997) describes voice as ...

“a struggle to figure out how to present the author’s self while simultaneously writing the respondents’ accounts and representing their selves. Voice has multiple dimensions; Firstly, there is the voice of the author. Second, there is the presentation of the voices of one’s respondents within the text. A third dimension appears when the self is the subject of the inquiry.....” (pp xi-xii).

My intent was always to privilege the voice of the participants. Therefore my telling of their accounts of their experiences was most important, and this is illustrated in

my presentation of the findings. My voice reflects the analysis of engaging with the findings and drawing conclusions related to the purpose of the study.

The Interviews

Interviewing is the major form of data collection in qualitative research. Interviews vary from the largely open-ended and less structured manner which allows participants to reveal their perceptions of the concept under study to a more structured format (Fontana & Frey, 2005). Face to face interviews provide the opportunity for in-depth exploration of issues under study (Mays & Pope, 1995). It has been suggested by Patton (2002) that while some specific information is usually required from each participant, a more relaxed, semi- structured approach is appropriate for most of this type of interview. The task for the interviewer "...is to make it possible for the person being interviewed to bring the interviewer into his or her world" (Patton, 2002, p. 341). Furthermore, "...qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit..." (Patton, 2002, p. 341). The use of a brief interview guide (Patton, 1990) subsequently provided some guidance to the questions to be asked, yet allowed me greater flexibility in the wording of subsequent questions as the interview progressed. Consequently, the research questions served to focus the development of questions which were utilised for these interviews. During the interviews, this framework helped keep the research focused, yet it allowed the flexibility to use emerging ideas and themes arising during interviews as further triggers.

However, interviewing is not without its problems for the novice researcher (Yin, 2003). The potential exists for the data to be subject to the bias of the

researcher and participants, to be rendered less than useful because of poor recall on the part of the participants or the inability of the participants to clearly articulate their experiences (Yin, 2003). Similarly, it is also important to remember that the data collected during interview represents the participants' unique perception and perspective of the events being discussed (Patton, 2002). Furthermore, the researcher is also bound by a selective perception of the situation. I am a registered nurse with 30 years clinical experience and am currently working in an acute care clinical setting so I was mindful that my 'voice' or perspective not dominate and influence the participants' responses.

Consequently, several measures were employed to increase the accuracy of the data collected. The interviews were tape recorded in order to provide accurate data for analysis and this allowed the participants and me to focus on the discourse rather than the process. The potential exists for there to be an influence over the interviewee spontaneity in responses and the interview process by the presence of tape recorders (King & Horrocks, 2010; Yin, 2003). However, audio recording advantages data collection by allowing the interviewer to listen and record contextual notes such as non-verbal behaviour and insights suggested by the interview. Interview data were transcribed by an experienced transcriber and then I listened to and edited the record of interview in order to engage on a deeper level with the data and begin the process of data analysis from which I could identify emerging themes. This form of data analysis was true to the research design and served to contribute to the trustworthiness of the thematic analysis.

Rigour in Qualitative Research

The conventional criteria for evaluating the methodological rigour of quantitative research include internal validity, external validity, reliability and objectivity (Guba & Lincoln, 1981). Applying the criteria of scientific rigour of quantitative research to qualitative research is problematic since the nature of the quantitative research processes differ and are inappropriate in evaluating qualitative research methods (Emden & Sandelowski, 1998). Rigour in qualitative research refers to the "...accuracy, verification and validation.." of the data (Silverman, Ricci & Gunter, 1990, p.59). This has also been referred to as the trustworthiness of the research.

Trustworthiness

The importance of trustworthiness in qualitative research is emphasised by a number of researchers (Guba & Lincoln, 1994; Holloway & Wheeler, 1996; Koch, 1995; Lincoln & Guba, 1985; Patton, 2002; Sandelowski, 1986; 1993) and a number of techniques are recommended to enhance the credibility of findings. While there is no consensus about rigour, in qualitative research, ensuring that knowledge derived from research findings are trustworthy and believable is essential (Koch, 1996; Popay, Rogers & Williams, 1998).

A number of authors have attempted to develop criteria to assess the rigour of qualitative research (Leininger, 1994; Lincoln, 1995; Lincoln and Guba 1985; Sandelowski, 1986). Morse and Singleton (2001) suggest that trustworthiness can be demonstrated with the application of four criteria. These include credibility, dependability, confirmability and transferability.

Credibility

Sandelowski (1986; 1993) presents a cohesive argument for returning to the participants to confirm analysis as one of the approaches for achieving credibility (Sandelowski (1986, 1993). Once data analysis was completed I recontacted the participants in the study with the aim of establishing creditability of findings by asking them to verify the accuracy of the thematic analysis undertaken. Lincoln and Guba (1985) label this as the ‘member check’ phase, as the task is to confirm that the data gathered and analysed has captured the understandings and meanings of the participants. Sandelowski (1993) argues that the credibility of a qualitative study is also enhanced when researchers describe and interpret their own behaviour and experiences as researchers in relation to the behaviour and experiences of the participants.

Transferability

Transferability is concerned with issues of conceptual generalisability of findings (Guba & Lincoln, 1994; Tobin & Begley, 2004); that is, how applicable are the findings to a similar setting or situation (Patton, 2002). To meet the transferability criterion, the account must be sufficiently comprehensive to allow the reader to determine the applicability of the findings to other contexts and the selection of participants must be appropriate to the aims of the study. This means that participants must have the knowledge and experience to provide appropriate information. Sampling in this study fulfilled the criterion of ‘fittingness’; that is, all participants to have knowledge and experience of acute care registered nurses, so their perspectives fit the purpose of the study. The sampling strategy included participants who were employed or carried out their practice at a number of acute health care facilities, and by patients from both the public and private hospital

settings. Transferability was also enhanced by using ‘thick description’ and the participants’ own words to report the findings. Denzin (1989) suggests that the responsibility of the researcher is to provide enough descriptive data to facilitate a judgement of transferability. Such description forms the “bedrock” for all qualitative research (Patton 2002). In this study, the inclusion of the verbatim accounts supporting the analysis provides a means by which the reader, and potential transferer can examine the experiences of the participants. If the description is thick, the reader should experience a feeling of familiarity and of being there. It should also build on the tacit knowledge of the reader regarding the situation or phenomena being researched (Lincoln & Guba, 1985).

Dependability and Confirmability

Dependability refers to the stability of data over time (Guba & Lincoln, 1989). Claims for confirmability can be made when there is a conscious effort to eliminate the researcher’s biases in the process of analysis. A judgement can then be made as to whether the findings convey the realities of the participants and not the biases of the researcher. Confirmability can be checked by an examination of the researcher’s documentation of the data, findings, interpretations, decisions and recommendations made during a project (Lincoln & Guba, 1985; Searle, 2001). The process establishes not only the confirmability of the study, but also the dependability of the study (Lincoln & Guba, 1985).

Auditability

Auditability relates to the consistency of the qualitative findings. This enables the reader (auditor) to clearly follow the systematic process of the researcher in conducting the research (Patton, 2002) which includes the decision trail left by the

researcher (Guba & Lincoln, 1994). Within this study, this chapter provides an audit trail that describes the methodology, context and reasons for decisions made to progress this study. My decision trail during the study included the use of a journal during the fieldwork phase of the study to record my thoughts related to the interviews. In addition, throughout the study I kept a log book where I made notes and kept a record about matters related to the progress of the study and the analysis.

Positioning the Researcher

It is clearly recognised in interpretive-based research, that the assumptions held by the researcher, and previous background and experiences with both research and the area under study influences the decisions made and processes of the research inquiry. As the researcher, I came to the study with 30 years of clinical experience in acute care settings in both general and specialty areas. I continue my clinical experience in the acute care setting, and in addition now also am a lecturer to undergraduate nursing students. I therefore consider myself to have a familiarity with nursing practice. Immersion in clinical practice and teaching over a prolonged period of time enabled me to question issues related to nurse performance in a way that a lack of clinical teaching and practice would prevent. Continued engagement in clinical practice has also enabled me to remain open to challenging my own interpretations of the data and construction of understandings, increasing the credibility of the data.

The Researcher as Instrument of Inquiry

In the context of naturalistic inquiry the natural setting often is complex in nature. The researcher is able to respond to and make sense of the many

cues contained in the natural setting and is therefore seen to be the instrument of choice for studies situated in the natural setting (Guba & Lincoln, 1981, 1989; Lincoln & Guba, 1985). In addition, the researcher is believed to be able to identify meaningful boundaries so as to render the study specific and in all probability, contained. Being adaptable is also seen as being an important quality for the researcher as instrument. This adaptability shows itself in the researcher being able to respond to changes in personal and environmental cues, levels of meaning, situational nuances and the ability to clarify and summarise at the time of data collection. How researchers and intersubjective elements impact on and influence qualitative research is considered an important aspect of qualitative research (Finlay, 2003).

The epistemological perspective, and the role of the researcher in interpretivist research is consistent with recognition that the researcher is very much *in* the research and not an objective collector of data. The researcher interprets the world through their own lens. This means that the research is a product of the researcher's world view, choices, actions, decisions, interactions with participants and his/her interpretation of the spoken perspectives and perceptions of participants and their behavioural cues. Therefore, the data are the result of interactions between interpreters and others (Koch, 1995). The researcher then conveys that interpretation to readers through the written report. As the research instrument in this study, I was both part of and apart from the experiences described by the participants. My experience as a registered nurse in the acute setting enabled me to 'speak the same language' as the participants as they reflected on their experiences. This resulted in greater rapport with participants.

SECTION TWO - METHODS

The purpose of this methods section is to firstly explain the actual steps and procedures taken and to specify the study's parameters. Secondly, to demonstrate the particular strategies for gathering data and analysing the data.

Study Setting

This research was carried out in the state of Western Australia, situated on the West Coast of Australia. The state is approximately one third the land mass of Australia. The capital city is Perth and has a population of 1.7 million (Australian Bureau of Statistics, 2010) with the remainder of the population, approximately 500,000 located in the remaining sparsely populated state. The majority of the remaining population resides in the South West of the state. The population as a whole is located in the coastal regions as the interior is mainly dry with poor rainfall, limited vegetation, and a sizeable portion of the state is desert. As with other states in Australia, a considerable number of residents of Western Australia migrated to Australia or their parents were born overseas. There is also a small and significant number of people of Aboriginal (first nations) descent residing in the state.

The participants resided and worked in the metropolitan area and in the south west of the state. Some participants had experience of working in the more remote parts of the state and so were able to recount experiences related to the isolated regions of the state. Within Perth, the capital city, the surrounding metropolitan area and in country regions of the state are both private and public (state owned and managed) hospitals. There are also a few hospitals in the state which are state owned but privately managed. The participants related experiences which occurred in these three types of hospital settings throughout the state, and therefore, the experiences

described were considered not exclusive to large university teaching hospitals located in the state's capital city.

Participants were interviewed at the location of their choice. These locations included the participant's home, workplace office/meeting room or interview room at the university. All patients were interviewed in their homes post discharge. Nurses were interviewed in their homes or at their workplaces if they had a management or educational role and therefore an office was clearly available. Doctors were interviewed at their workplace, Occupational Therapists and Physiotherapists were interviewed at their home or workplace, and Social workers were interviewed in their workplace. One participant chose a café where she felt better able to participate uninterrupted by her children who were settled for the evening at home.

Sample

According to Patton (2002) the purpose of sampling in qualitative research is to expedite in-depth understanding, rather than empirical generalisation. Therefore purposive sampling was used to recruit participants to inform the study. The sample consisted of 15 general nurses, four mental health nurses, 13 medical doctors and allied health professionals, and 13 people who were former patients in general hospitals and mental health units. In total, data were analysed from 45 participants. Most of the former patients had been hospitalised for a surgical intervention or an episode of ill health. All were interviewed at least two weeks post discharge to ensure that the patient was reasonably recovered from their hospitalisation. Criteria for inclusion in the study as a patient or health care professional included:

- Patients who are at least two weeks post discharge but no more than six months post discharge. This timeframe allowed patients to be over the main effects of their hospitalisation and but not too far away in terms of time from the

experience. Patients who were hospitalised for at least three days so that they accumulated some experience about the topic under investigation.

- Registered general nurses and registered mental health nurses who were currently practising. These nurses were either clinical nurses, nurse educators or nurses working in a management role, including a clinical management role employed in a hospital setting.
- Medical and allied health personnel who were currently in contact with registered nurses in a health care facility.

Exclusion Criteria were:

- Registered nurses and mental health nurses not currently employed.
- Medical and allied health personnel who do not provide professional services at a health care facility.
- Non English speaking patients. Interpreter costs were not able to be funded for this study.

Recruiting Participants

I engaged in an eclectic approach to participant recruitment. Some participant groups were difficult to recruit, particularly patients and so a number of different recruitment approaches were required.

The registered nurses were recruited through the Nurses Board of Western Australia. Four hundred registered nurses and registered mental health nurses were randomly selected by Board staff and mailed a letter of invitation, my contact details, and a tear off section on which the potential participant provided contact details in the return paid envelope. Medical practitioners were recruited from a metropolitan tertiary hospital, and metropolitan and country private practices. Each potential participant received a letter of invitation explaining the study and requesting

participation in the study with my contact details and a tear off section providing contact details of potential participant with a return paid envelope. Some medical practitioners did contact me commenting on the importance of the study but stated they were too busy to participate.

Physiotherapists were recruited through the West Australian branch of the Australian Physiotherapy Association. Five hundred physiotherapists received a letter of invitation to participate in the study through a selection process which included the use of post codes to ensure that both metropolitan and regional/rural physiotherapists were contacted.

The Social Work and Occupational Therapy professional associations declined to conduct a mailout of my letters of invitation to the study because they lacked resources but suggested that I contact the Head of Department of the allied health department of a metropolitan hospital. This I did, and my letters of invitation to participate were distributed through the hospital's medical education officer to both the medical practitioners and the social workers and occupational therapists. This person was not involved in the supervision of any of the staff at the metropolitan hospital and was deemed to be the person of contact by the institutional ethics committee.

A number of approaches were used to recruit patients. Patients from general acute care wards awaiting discharge in the transit lounge at the metropolitan hospital who met the inclusion criteria were given a letter of invitation by nurses staffing the transit lounge. Transit lounges are part of all large metropolitan hospitals. The lounges are for patients who are discharged from hospital but not able to be transported to home or other destination by ten o'clock in the morning. Therefore

patients are directed to the transit lounge and this enables the vacated ward beds to be utilised by new admissions.

Some patients from the transit lounge responded to me and appointments were made to interview them at home. However, this method of recruitment proved to be problematic in that there was a poor response from the patients. Following discussion with the Nursing Director of Research the decision was made that I attend the discharge/transit lounge. This would enable me to explain the study and invite patients to participate unencumbered by the work requirements of the transit lounge nursing staff. I met the Nursing Director of Research on the appointed day and she introduced me to the transit lounge staff.

A number of patients presented over the course of the day to the transit lounge. One patient seemed too ill and still in need of a recovery period. He was travelling on a bus to the country that same afternoon. Another patient was returning to the local prison and thought it unlikely that the prison authorities would allow me to interview him. He commented that he had received very good care and volunteered that he had not been treated any differently to the other patients on his ward. Two patients were lying flat and motionless on stretchers awaiting transfer to nursing homes. One patient wanted to read her letter of invitation at home. I did receive a notification slip of interest in the study however no contact details were provided. At the end of the day I had recruited one patient into the study.

Recruiting of mental health patients was originally undertaken by approaching the metropolitan hospital's mental health unit. Following discussion with the nurse manager of the mental health unit, letters of invitation were placed in the patient's discharge information package. This approach yielded no responses.

Therefore, an advertisement was placed in two community papers requesting participation from people who had been inpatients in general hospitals and mental health units. I also advertised with the use of flyers at general practitioners' surgeries, community libraries and the university campus. A number of people contacted me. This approach enabled me to obtain a suitable number of patient participants. The data collection period was therefore extended over a longer period of time than originally anticipated, a total of 18 months.

Data Gathering

The data gathering included an initial phone call by myself responding to the potential participants initial contact. The study was explained during the phone call, particularly the need to audiotape, and agreement obtained that the interview could take place and a location, date and time set.

On arrival at the designated time and place for each interview, I first tried to help the participant feel at ease by the initiation of social ice breakers and general conversation. This technique developed as the interviews progressed. Once I had developed a rapport with the participant, the purpose of the project and the format of the interview were discussed. Following this explanation verbal acknowledge of the participants continued wish to participate in the interview was sought. The consent form (Appendix A) was then explained to ensure the participant understood their ethical rights concerning informed consent and the opportunity to ask questions was provided. Two copies of the consent form as advised by the institutional ethics committee were signed, and one was given to the participant to keep, and I kept the other. The participants were then asked to complete a short demographic form (Appendix B). Following this the tape recorders were tested, position and volume adjusted, if necessary, and the interview commenced. Two tape recorders were used

during the interviews as a fail safe method. If there was a malfunction with one then the second would still record the interview. The participants all consented to this method of recording the interview and some expressed the idea that it seemed very sensible given the antiquity of one of my recorders. Two interviews were conducted with only the smaller tape recorder as the interviews were conducted out in the open and both of the recordings were indecipherable because of the competing noises, mainly traffic sounds, and therefore not transcribable.

During the interview I recorded brief notes in a notebook about what seemed to be important key words that the participant used as a descriptor and then followed up later with questions about what I had recorded. An example,...“ You mentioned earlier that the nurse you are describing always seemed to know what was going on in the ward. How did you know that?”

When the interview had concluded and the tape recorder had been switched off, I usually spent a few minutes in conversation with the participant before leaving. Some of the patients interviewed had particularly difficult hospitalisations in the general acute sector. They appeared to need to debrief about some aspects that had been discussed before the interview was concluded. I thought it important to be available to conclude the conversation with the patient when the patient was more relaxed. In these situations I think it is important to continue to remain awhile rather than leave immediately at the conclusion of the interview.

Following transcription of the interviews and checking by myself I posted the interview transcript to each participant so they would have the opportunity to verify or change the transcript. They were asked to read through the transcript and to make any corrections directly onto the record of interview and then return to me in the provided reply paid envelope. Some of the participants made changes. These were

mainly to overcome the “em’s and er’s” that had been included during transcription and to complete some of the gaps that had been marked as “inaudible”. Two participants made further changes which improved the grammar and sentence structure of their record of interview. The transcripts were later adjusted accordingly.

Interview Process

In-depth interviews were undertaken for this study. In depth interviewing takes an unstructured, conversational style to questioning rather than an interrogative style (Minichiello, Madison, Hays, & Parmenter, 2004). The aim of this style of questioning is to engage with the “...subjective interpretation and evaluation of the events...” ((Minichiello et al, 2004 p:412).

My initial question asked the participant to describe what she/he thought a satisfactory, good or outstanding nurse was and I then suggested the participant could respond in any order. The focus of the study was to be individual nurses who were perceived to be satisfactory, good and outstanding. However, I thought it necessary to open the interview in this way as most of the early participants were enthusiastic about the topic area and were well prepared with their responses. They confessed to having given the topic considerable thought exemplified by comments such as “...I was thinking about this last night...” or “...I discussed this with my colleagues yesterday...”. Another frequent comment included “...and I have made a list...”. My intent was to not have descriptions of the idealised nurse but rather accounts of interactions with real world nurses. To achieve this it became apparent that it was best to allow the more general question take precedence before proceeding to the more specific. This was then achieved by suggesting to the participant that they think of a nurse who they think is satisfactory, good or outstanding and then describe how that nurse interacted and went about his/her work.

The participants responded in the order they wished allowing the participant to commence where they were most comfortable and this technique aided a more conversational approach to the interview.

Spradley's (1978) approach to ethnographic interviewing was used to elicit responses. This included asking descriptive, structural and contrasting questions. My initial questions were descriptive asking for examples and experience. These questions started by asking the participants to describe the satisfactory, good and outstanding nurses. I also utilised structural and contrast questions. An example of a structural question from my interview with patient 10 is, "There's a couple of words here... compassion. So who was compassionate and what was she doing while she was compassionate?" An example of a contrast question I asked was "So, the difference between this nurse and the outstanding nurses was....?"

I concluded each interview by thanking the participant and asking whether the person wanted to say anything further about the topic or whether the participant had expected to be talking about something else all together. Patton (2002) suggests that in the spirit of emergent interviewing the inclusion of a final question allows the interviewee to have the final word.

Most of the participants agreed that the nature of the conversation reflected what they had anticipated the interview would be about. Two nurses voiced that they thought they would be talking about themselves and the work they were involved in. One of the nurses was a nominee for a national professional award and the other was working in part in the area of costing analysis. This final question then gave them an opportunity to talk about their work.

Field Notes

In addition to the field notes recorded during interviews I also prepared reflective notes during the study. Following the interview I found a quiet place (usually in my car at the local park) and wrote notes in my notebook about the interview and any events that occurred during the time with the participant, and any events that impacted on me that may be relevant to the study. According to Lincoln and Guba (1985), field notes keep the researcher alert and responsive and allow ready access to return to earlier points and offer the researcher the opportunity to record thoughts that may add to the study and be followed up later. For example, the conversations that occurred pre and post the taped interviews were recorded in note form. Descriptions of the context and people at the place of interview were also noted.

Ethical Issues

Implicit in the human sciences is a respect for the dignity and rights of the individual. I acknowledge that both in the field of research in general and the health arena these principles are paramount. I was aware that participation in the study had no reward for the participants other than that intrinsic to furthering the body of knowledge.

Orb, Eisenhauser and Wynaden (2001) identified the importance of attending to three principles of ethics in qualitative research: autonomy (informed consent), beneficence (preventing harm), and justice (protecting the vulnerable). These principles were integrated into the design of this research project and I was considerate of these aspects throughout the study in the way that I engaged with study participants, as well as the way in which the data were safeguarded and managed.

The research proposal for this study was submitted to the Edith Cowan University Human Research Ethics Committee. Following approval the Director of Nursing Research of one metropolitan public hospital in Western Australia was contacted and the proposal was submitted to the hospital's ethics committee for the purpose of recruiting patients, medical staff and allied health personnel into the study. The Nurses Board of Western Australia and The Physiotherapy Association – Western Australia accepted the university research committee's permission to proceed with the research. For the second phase of the study ethics approval to recontact the participants was granted by Murdoch University's Human Research Ethics Committee.

Potential participants in this study were informed of the purpose and voluntary nature of participation in the study. In particular, the patients were informed that their participation or non participation would not affect their on going care in any way. The participants were informed of their contribution to the study and assurance given that all information provided would be treated in a non-identifiable, confidential manner. Opportunity to ask questions about the study was provided and the right to withdraw at any time without penalty restated. Once the participant was satisfied with the requirements of the study, a consent form was signed (Appendix A). Each participant and I signed two consent forms and we both kept a copy. Participants were identified on the record of interview transcript by a numerical code. Only I knew the identity of participants and I kept names and addresses in a secure place separate to the transcripts in a locked filing cabinet. I took steps to ensure that participants were not identifiable by the information that they provided. There were no perceived risks identifiable associated with participation in this research.

The tape-recorded interviews were deleted on completion of the study, and the transcribed interviews, memos, field notes and journals placed in a safe place for a period of five years. Computer files related to this research were protected by a password which was only known to me.

During the interviews, because of the sensitive nature of the information being provided, participants were asked to be careful to conceal the names and details of the nurses and the health care facilities they were describing. Where any nurses were referred to by name this was recorded by initial only. In addition the participants were cautioned by the interviewer regarding the information they provided. There was no intention that the research would insult anyone or be an indictment on the management of a particular ward or unit.

Potentially this study could have revealed information about negligent behaviour of individual nurses. In instances where negligent care is provided, these matters are reported to the ward managers and may be deemed necessary to report to the registration authority. Two participants revealed information about poor care. Both individuals had been given personal assurances at the time by the ward managers that the problems were being addressed and the participants were satisfied with the way in which the situations had been handled.

Data Analysis

Data analysis began with data collection. Most of the data generated was in the form of text – interview transcripts and, to a lesser extent, field notes that were written following the completion of each interview. In a previous section of this chapter I explained that during the interview I made brief notes on key points and returned to these points to discuss with the participant as the interview progressed. Therefore data analysis occurred between the participant and the researcher during

the interviews, and between the researcher and the data (the transcripts and the emergent categories) following the interviews. Furthermore, as the study progressed, data analysis moved back and forward between the past, in the context of prior transcripts and different participants, and the present participant's interview. The transcripts once transcribed and checked for accuracy against the recording of the interview were read a number of times to get a sense of the whole. Roberts and Taylor (1998) suggest that a number of readings need to be undertaken so that there is familiarity with the nuances of the text. The main objective of data analysis was to generate themes from participants' responses. Meaningful units were identified through an iterative process and placed into provisional categories from which the themes were developed. While reading the transcripts I undertook to answer the analytical question "What does this best illustrate?" As I read the transcripts I made notes in the margins as suggested by Ezzy (2002). Categories that seemed incomplete were followed up with further data collection and analysis. Follow up was conducted with subsequent participants and with all participants at the end of the study in the style of member checking.

Thematic analysis followed the guidelines of DeSantis and Ugarizza (2000). These authors conferred that themes arise from the data and are more abstract and general than categories. They suggest that "As abstractions, they have intellectual and affective content that depends on intrinsic form rather than on narrative content or pictorial representation" (2000, p361). Defining a theme relies on four criteria. The first is that the themes emerge from the data. The second is that the themes are implicit and embedded in the data "...and must be extracted or inferred from the data by the researcher" (2000, p363). The third criterium for theme identification is that a theme is an iteration or recurrence. This particularly refers to behaviour or ways of

thinking, feeling or acting. Therefore, themes are embedded in repetitive or variant, often disparate expressions of social behaviour or verbal interaction. The fourth criterium is one of conveying a sense of wholeness and holistic meaning, rather than merely a category or component of a theme (DeSantis & Ugarizza, 2000).

The process of data analysis commenced while the interviews were in progress and continued through several iterations. Just as field work is not a linear activity, analysis involves an iterative search through the data to identify meaningful units and categories of analysis (Strauss & Corbin, 1990). The data were examined for recurring regularities, as a way of dealing with what Patton (2002) identified as convergence within the data. Therefore, the analysis represents a more subtle process than what consensus implies. Data analysis in this study reflects common experiences with regard to the perceptions of satisfactory, good and outstanding nurses. During this iterative process, the analysis was re-examined and checked. The identified categories were re-examined for regularities that seemed to capture the essence of the meanings or experiences and behaviours across numerous circumstances and situations, reflecting abstractions that represented higher order concepts or themes (DeSantis & Ugarriza, 2000). The themes illustrating recurrent behaviours and experiences were abstracted from the data; that is from the verbatim interviews and to a lesser extent the field notes. This process of data immersion allowed for data that initially may have been thought as insignificant when viewed alone as information from only one participant, to develop more meaning when combined with data from other participants. Therefore, the themes derived from the data were the larger units of analysis that linked relationships and experiences within the cultural context of acute care nursing (DeSantis & Ugarizza, 2000).

The QRS Non-numerical Unstructured Data: Indexing, Searching and Theorising version 6 (QRS N6) program was used to store the data generated by the study. The meaning units were assigned to categories (coded as free nodes in QRS N6). Once all meaningful units were assigned a category, the categories were reviewed and refined. Refinement meant that some categories were combined or broken down.

Meetings were held with my research supervisors at the time of data collection to discuss data collection and consider emerging themes and categories. Inconsistencies were dealt with by re-evaluating the initial transcripts and decisions made (DeSantis & Ugarriza, 2000). The iterative process of data analysis then continued after data collection was completed.

Participant Verification

A second phase in the study was undertaken after the initial phase 1 interviews and completion of data analysis. The second phase aimed to establish research rigour with the findings generated from the initial interviews. This phase served to verify the accuracy of the thematic analysis of the interviews conducted earlier. Lincoln and Guba (1985) identify this as the ‘member check’ phase as it is necessary during this phase to obtain confirmation that the data gathered has captured the essence of the participants’ construction of the data. During this phase Lincoln and Guba (1985) suggest the researcher correct or extend the data in conjunction with the participants to establish credibility of results.

Following data analysis and completion of a summary of the findings a process to assist in verifying the study findings was initiated. Ethical approval was granted by Murdoch University’s Human Research Ethics Committee for this phase

of the study. A cover letter (Appendix C) was formulated giving instructions for how the participants could assist in establishing accuracy of the findings; a copy of the findings summary was attached (Appendix D) and Consent form (Appendix E); a self addressed envelope was included along with a comment sheet. Participants were advised that they could make notes on the comment sheet and post that to the researcher in advance of the researcher contacting them. The researcher telephoned following contact from participants to discuss any issues that related to the findings.

When participants were contacted by telephone and interviewed, the researcher asked them to comment on how they felt about the findings summary; whether they noted any discrepancies with the summary; whether they were in agreement with the findings and whether they had any further comments following the reading of the summary.

The researcher was able to speak with 17 of the 45 participants in the study and gained feedback from these people over the telephone. Some individuals (six) had preferred to write their comments and posted these to the researcher. There were five participants from phase 1 who had not indicated to me a mailing address. Our contact had been as a result of responses to advertising and we had made arrangements for interviews by phone and therefore I was not able to send the transcripts or summary of findings to them. One participant was ill in hospital and the next of kin contacted me indicating that the participant was too ill to provide further information. Three participants had changed address and so their envelopes were returned to me unopened. The remainder of the phase 1 participants did not respond to my request for contact and as I therefore did not have a signed permission slip to make further contact, I did not contact them.

Two months for gathering feedback from participants was allowed. A second round of invitations to comment with summary findings included was not attempted as I felt that the participants had been given the opportunity to respond and therefore failure to receive a response from the participants most probably meant that they had declined the invitation. The findings chapter includes a section which highlights a summary of these comments and provides some reference to examples of the feedback received from study participants.

All the participants who I was able to contact were delighted to receive feedback and seemed genuinely pleased to be followed up after the initial interview. As one participant commented, “It’s great to receive feedback when you participate in a project”. Only a small number of the participants who were interviewed posted in or made notes on the findings summary sheet, preferring to discuss the summary findings.

As anticipated the majority of participants agreed with the findings presented to them. The researcher was frequently greeted with confirmatory comments like: ‘Thought it was a good summary report’; ‘I would agree with what you’ve said and how you explained it’; ‘Your findings are what I would agree with’; ‘It was a pleasant surprise because it’s what I thought also’.

One participant commented that the situation where the nurse was observed to be a very pleasant and caring but was not knowledgeable and therefore may be a risk to the patient safety was not referred to in the summary. We discussed the idea that satisfactory nurses were often seen as being safe to practice in the sense that they did not do any harm but weren’t particularly effective in terms of decision making and intervening for the benefit of the patient. I think this type of nurse is described in the study as being satisfactory. The nurse who doesn’t do any harm but

doesn't necessarily do much good because of their lack of intervention skills, what ever the circumstances for the patient. In the discussion chapter I elaborate on this. Another participant commented that "the description of the satisfactory nurse is unacceptable in the sense that it's almost unsatisfactory". This comment echoes a comment made by a participant that I reported in the findings chapter. While the two comments above do not describe a discrepancy they add to the explanation of satisfactory nurses as they support findings of the study which were not put into the summary report because of the need to be parsimonious with the summary report details and length. A shorter length of report is more likely to keep the reader engaged.

One participant commented that since participating in the study she 'had most probably had other thoughts over the time and named the issues of age referring to the ageing workforce, busyness, workload issues, and always working short which the participant stated can affect people's health and how they go about their work. This led to a discussion about work intensification which we both agreed was important.

Summary

This chapter has outlined the inquiry paradigm, its ontology, epistemology and methodology. I have described the methodological processes and the methodological decisions which underpinned the study. The chapter outlined the sampling, data gathering, analysis process and the ethical issues for the study. I have also indicated where methodological issues arose in the study. The next chapter will provide the findings of the study.

CHAPTER FOUR

FINDINGS

Introduction

Spoken accounts allow the speaker to give more details and include concerns and considerations that shape the person's experience and perception of the event. A story of an event is remembered in terms of the participant's concerns and understanding of the situation (Benner, 1994, p.110).

This chapter reports on the participants' responses to the interview questions.

A number of major themes emerged from the qualitative data when interpreting the experiences and perceptions of the participants about satisfactory, good and outstanding nurses. Descriptions of outstanding nurses yielded prolific data which are clustered into five major themes each with a number of subthemes.

Interpretations of comments on good and satisfactory nurses are categorised into five major themes each. These are reported separately and will be addressed in depth in relation to the participants' reported experiences with registered general nurses and registered mental health nurses who they identified as being satisfactory, good or outstanding nurses. The findings reveal variability in the participants' perceptions, with differences in their descriptions within each group, but some common themes. These themes are presented as interpretations of satisfactory, good and outstanding practice.

Demographic Data

All the participants were over the age of 18 years and able to converse well and freely in the English language. The demographics for the participants are shown

in Table 4.1. The participants all had current or recent participation in the acute health care sector. The ages of participants ranged from 19 – 82 years.

Table 4.1

Overall Participant Demographic Information

Age	Frequency	Percent (%)
0 – 19	1	2
20 – 40	12	26
41 – 60	28	61
61 yrs and over	5	11
Gender		
Male	12	26
Female	34	74
(N = 46)		

Table 4.2

Practitioner Demographics

Practitioners	Frequency	Percent (%)
General Nurses	8	24
Mental Health Nurse	4	12
Nurse - Other specialised practice	5	15
Nurse – Admin / Research / Education	3	9
Medical practitioner	2	6
Allied health	11	34
Education		
Diploma	8	24
Bachelor	16	49
Higher Degree	9	27
Years of experience		
1 – 9	4	12
10 – 19	9	27
20 – 29	9	27
30 – 39	10	31
41 – 50	1	3
(N = 33)		

Table 4.3

Patient Demographics (N=13)

Patients	N	Percent (%)
Retired	4	31
Employed	4	31
Student	2	15
Homemaker	3	23
Length of Stay		
3 – 15 days	8	61
16 – 31 days	1	8
32 – 120 days	4	31
(N = 14)		

The participants are described in Tables 4.2 and 4.3 as two groups; health professionals and patients, with slightly different demographic characteristics. The average age of the former patient group was 53.62 years. There were eight females and 5 males in this group. Five of the participants were born in Europe, one in Asia and the rest were born in Australia and New Zealand. With regard to cultural background, five described themselves as Australian, one as New Zealander, one as Northern European, one as Scottish and three as Angloceltic. Four were retired, three were homemakers, two were students and the remainder indicated their employment as management, self employed, professional and laboratory technician. Their level of education ranged from less than junior high school to university degree. The time interval since their experience as an inpatient ranged from two weeks to 6 months.

A range of hospital stays was represented, from three days to 120 days. The average length of stay in hospital was 30.38 days, with six former patients having

been in private and seven in public hospitals. All met the criteria of being within six months of hospitalisation, with the range or recency of hospitalisation being from two weeks to six months. The areas of hospitalisation were mental health unit(3), medical ward(2), surgical ward(6) and orthopaedic(1). A number of patients discussed their experiences in the operating room and the emergency department. Eleven of the patients were interviewed at their homes and two specified other places which were the university and a park.

The health professionals are described in two groups. The first group, the nurses, consisted of 15 currently practising general and three mental health nurses. Four male nurses participated in the study. The average age of the group was 39.33 years and their average years of experience 25.06 years. Their level of professional education ranged from diploma to higher degree. The nurses worked in a wide range of areas including; mental health, operating room, management, education, surgical, medical, oncology, gynaecology, dementia care, orthopaedics, plastic surgery, gerontology, emergency department, coronary care and intensive care (country unit). Some of the respondents had additional responsibilities such as research, quality improvement and clinical education. Some nurses were interviewed at their work place and some at their homes, the university or another requested place.

The medical practitioners and allied health professionals were the third group of participants. Combined, there were thirteen participants in this group. The average age of the group was 44.23 years ranging from 22 to 57 years. Their average years of experience as a health professional was 19.69 years. This group of participants worked in a number of areas including; general surgery, general medicine, palliative care, orthopaedics, oncology, gerontology and rehabilitation. This group were in contact with a registered nurse either daily or weekly and therefore had current

experience about registered nurses. Their level of education ranged from diploma to higher degree. Most of the participants in this group were interviewed at their workplace. The workplaces were in the metropolitan and regional areas of Western Australia. The remainder chose their home or an office at the university as their site of interview.

Forty six people were interviewed for this study. However, two of the tape recordings were not transcribable because of the poor quality of the sound recording and therefore the information from forty four participants only could be included in the findings. All participants commented on satisfactory, good and outstanding nurses in general terms. That is, the participants offered an opinion on what characteristics nurses at these three performance levels needed to have. This study was specifically interested in their experiences and therefore only data about their experiences were included in the findings of the study. Of these forty four participants, 30 commented on outstanding nurses, 32 mentioned good nurses and 29 commented on satisfactory nurses.

Thematic Analysis: Outstanding, Good and Satisfactory Nurses

There were five distinct themes that emerged in my analysis of the data regarding outstanding nurses. The major themes were: Sustaining a High Level of Performance, Modelling Exemplary Professional Behaviours, Balancing the Personal and the Professional, Managing Self and Others and Forming Personal and Therapeutic Relationships. Good nurses were seen to perform well in the clinical setting with some reservations. The five themes identified were Reservations about Clinical Competence, Limitations in Communicating, Inconsistencies in Working Collaboratively, Caring Style and Coping. Satisfactory nurses were perceived to

perform at a basic minimum standard which met patient safety standards. The major themes identified were Primarily Attending to Physical Care, Providing a Minimum Standard of Care, Selective Caring, Lack of Demonstrated Problem Solving Skills and Limited Personal and Interpersonal Capabilities. The themes and subthemes for the outstanding nurse are represented in Table 4.4. below.

Table 4.4 *The Outstanding Nurse*

Themes	Subthemes
<i>Sustaining a High Level of Performance</i>	Maintaining Clinical Knowledge Creating a Culture of Safety Being Client Centred Ensuring Care Requirements are Met Managing the Unit
<i>Modelling Exemplary Professional Behaviours</i>	Valuing Nursing Showing Compassion Respecting Others Being Reliable
<i>Balancing the Personal and Professional</i>	Being Happy at Work Being Genuine Showing Personal Warmth Being Enthusiastic Having Energy Being Well Groomed
<i>Managing Self and Others</i>	Being in Control of Self Being Calm and Coping Supporting Others Being Visible Being Attentive Being Available
<i>Forming Personal and Therapeutic Relationships</i>	Using Situationally Appropriate Skills Demonstrating Exemplary Communication

Each major theme is identified in this chapter with a bold heading. The subthemes concerned with each major theme are identified at the start of the explanation of each new theme, and then highlighted and italicised as they are discussed in the text. This chapter includes examples of verbatim quotes from the transcripts as evidence for the findings. These direct quotes used throughout the findings of this study are “*italicised*” together with quotation marks to indicate that the quote is taken from the transcript. Quotes are included within the paragraph together with quotation marks if their length does not exceed 40 words. The examples are referenced by the participant’s research code number and location within the source transcript. Some quotes were edited to delete repetitive speech and this is indicated by the use of three dots To clarify the intent of the words in the quotes when I thought they may be unclear additional words were added within parenthesis [for example]. In addition, pauses in participants narrative have been indicated as ...(*pause*)..., and where participants have used a manner of speech such as ‘err’ or ‘umm’ these are also included in the examples from transcripts.

Outstanding Nurses

The themes outlined below reflect a somewhat consistent perception by the participants. However, in one case the participant identified a nurse as being an outstanding nurse in performance because she was very efficient and knowledgeable but described her as having poor communication skills.

The five themes relating to outstanding nurses demonstrated their leadership skills within the context of the clinical setting. In this study the clinical context involved a number of clinical areas. These included general medical and surgical wards, operating room, mental health units, intensive care, coronary care, palliative

care, oncology, emergency department, orthopaedic, gerontology, rehabilitation, burns and plastics unit, gynaecology and dementia unit.

Theme One: Sustaining a High Level of Performance

The first major theme that arose from data analysis was “Sustaining a High Level of Performance”. Participants identified that outstanding nurses performed at a high level and were able to consistently maintain a high level of performance. Seven sub themes became evident from the data under this major theme, and these were: Maintaining Clinical Knowledge, Creating a Culture of Safety, Being Client Centred, Monitoring, Managing the Unit and Ensuring Care Requirements are Met.

A key element in the outstanding nurse’s repertoire of skills was being credible and competent in the provision of nursing care. The outstanding nurses were identified as having greater knowledge than other registered nurses which was easily identifiable, and this knowledge was either general in nature or related to their specific area of practice. They demonstrated their competence in both the essential and extended skills of the nurse.

“The person I am thinking of ... extremely good knowledge base and I guess experience would have a lot to do with that. So quite a lengthy experience, ten years and over of nursing experience in a variety of areas.” (N6 59 – 63)

Interviewer: “... the nurse that you have described here as outstanding ... you’ve said you get general type patients in there sometimes, medical and gynae and all that sort of thing. So the nurse, your outstanding nurse is actually a midwife?”

“Yes she is but I think she has worked in all areas. She is competent wherever she works.” (N8 610 – 615)

Maintaining Clinical Knowledge

Outstanding nurses were seen to demonstrate a higher level of clinical knowledge, which was identified as being extremely important. Their high

level of clinical knowledge was also described as being supported and linked to clinical experience.

“It’s that ... (pause) ... the clinical knowledge is there, you know that, little things like, they’ll question a medication that’s been given, they’ll go, ‘oh hang on, this is a bit too much’, and they’ll talk to the doctors, or the pharmacist, and the pharmacist will go, ‘oh yeah that’s correct’, and you go ‘oh, ok, she’s on the ball.’”(P5 358 – 363)

“...they knew what the side effects of the medicines and when you spoke to them, they could tell you this was going to happen and then when you said ‘my mouth is dry’ ... ‘well this is a side effect, I’ve told you that. So it is going to last for another three weeks.’ ... Just because in the way in which they spoke and from everything else around that they had done you could see that. You just knew if they said something that it was right. ... So I could respect their knowledge so that when they said to me it is going to take another three weeks you knew it would probably take another three weeks.” (Pt9 541-565)

The outstanding nurse was well respected because of that level of knowledge and sought out for an opinion related to patient care. A social worker commented about the nurse she identified as outstanding,

“I think you know the feedback and the sort of things that people say about this nurse ... they feel very positive about her skills, they feel very positive about her as a person, as a caring individual, as a caring nurse, as somebody who really knows what they are talking about and she is also somebody that people tend to turn to for advice, like people will, a range of people will ring for her, for her advice on patients, ... ” (SW3 167- 173)

A number of participants identified outstanding nurses as having a high level of knowledge and skills, by either having completed further education or being in the process of gaining further knowledge through further education. They saw a relationship with being an outstanding nurse and undertaking or having undertaken further studies.

“So it was concern for me and my wife’s welfare, making sure that ... (pause)... and she is one of the ones that has gone on to do the stomal therapy course so she had a better understanding of how to help the patients in that ward, because a lot of the patients in that ward, finish up with some

sort of bag you know after the operation whatever. She knew a bit about it but she didn't know enough, so she was prepared to make that sacrifice I suppose, or I suppose it is a sacrifice to study as you have got to do assignments and this that and the other so she was prepared to develop her own skills which were going to benefit her patients even more. And I think that that is one of the things that is quite important. What else about her?" (Pt9 310 – 320)

I asked one participant how she knew that the nurse was knowledgeable, and she responded;

"It just came across what they did and also one in particular and maybe others she did a lot of related study. .. I found her, the first time I met her, I found her really good to talk to and I learnt a lot from her. ... then after that I mean you know, it was just like with everyone else but she didn't, she spoke about herself more, but she knew a lot about related things in as far as not mainline medicine."(MHPt1 261-266)

It seemed that for nurses to be identified by others as being outstanding they needed to be knowledgeable about their area of practice and, as the participant below identified, could articulate their knowledge on a daily basis in a way that was meaningful for patients and other health professionals. One participant commenting about the outstanding nurses she had referred to said,

"I got a sense about both of them that they had done other study, that they were committed to that. They were at the forefront of the work that they were doing and they could articulate that in a sort of daily [way in the] work place." (SW2 395-398)

Creating a Culture of Safety

Participants valued a nurse's ability to maintain a safe working environment. In particular, participants commented on how much they appreciated the fact that outstanding nurses could manage the behaviour of others or situations as they arose so that they (the participants) felt safe. This feeling of safety or security and how it seems not to be taken for granted or assumed was important and described across a number of work environments, including mental health areas, operating room, general wards and the emergency department. When participants referred to safety

some of their accounts were related to safety from or about aggressive behaviour from patients and staff. Other accounts focused on feeling safe from chaos and panic. The net effect was that people felt safe in carrying out their practice.

“Well. She’s a senior nurse, she coordinates a good team and I know as a junior, as a very inexperienced junior, if I am in the theatre with a particularly difficult surgeon then I know it sounds stupid, but I feel safe. Maybe scenarios, ... [talking about a surgeon]we’ve got down here and this nurse always does his list. It is just that the potential problems are nipped in the bud, she just handles him so well. He starts like “Oh nurse! this is not - this is not the one I use” and the volume just starts going up and she will just cut him straight off. She’ll go ‘You’re right, I will go and get the correct one right now and I will write that down on your list to make sure that this does not happen again.’ Cut(s) him off straight... .”(N4 112 – 159)

The account below is from a male nurse working in the mental health area who identified that stressful situations did arise when patients were aggressive but the outstanding nurse he identified was able to provide a clear plan and delegated well in this situation which enabled him to approach his work with a feeling of reasonable safety.

“... other people would be, Oh No! Like this has happened[!] We have to hit all the buttons and call other people and it would seem to be a bit more panic than rush. Whereas she just seemed to be able to control everyone and delegate and you felt fairly safe, like I feel safe going into a room, ... (pause)... [if] we had to go in there and treat this patient, and I felt safe doing it.” (MHN2 375-382)

One participant stated that she had comments from patients who were able to identify something about a certain nurse who she felt safe with when he was on duty. Patients responded well to him and therefore this promoted a safer environment.

“... the patients who could very easily [become] out of control, it probably has got to do with respect, but I don’t know what else it would be, they could be with another male nurse and they get aggressive and say ‘I won’t’ and ‘Give it to me now’. Whereas he can sit down and say well they’re not going to do it and they tend to listen. ... you know that when that person is on that your shift, it is going to be a good shift and when you get a patient say ‘Oh

good that nice man is on so it is going to be okay'. So they feel safe." (MHN3 144-150)

A nurse working in a ward area also told of her experience with an outstanding nurse whose responses promoted a feeling of safety. In this case the outstanding nurse went beyond acting in a supportive way. The support extended to providing safety in the ward environment.

"If you had any difficulty with for example one of the doctors, which was bound to happen in this particular area, and I went to her, she said 'Leave him to me'. She went and told him off good and proper. You felt safe. You could safely practise ... she was going to look out for you as well as everything else." (N2 261-265)

Nurses frequently identified the co-ordinator of the ward as managing the ward and staff in such a way that it promoted feelings of safety. I asked one participant to describe an outstanding nurse keeping in mind a particular nurse,

"She's very efficient, but she is very kind to all her staff members. She is always pleasant, when she is on you think beaut she is in charge. She is a level 2, and I think beaut, I know the ward will run really well today because this particular girl [registered nurse] is in charge She is always checking up to make sure that we are managing our patient load. She just does it very, very well and I always think, lovely she is on. I feel very safe." (N8 160-217)

One of the patient participants commented on how the nurse she identified as outstanding contributed to her feeling of safety.

"Like if I did something wrong that day she would sit me down and she would be like 'Why did you do that?' ... go through all the steps of ... and yeah, she would like make me think about my actions, and think about me and where I wanted to go. It wasn't like she spoilt me but it was ... (pause) ... just made me feel really safe and stuff." (MHPt3 54-59)

Being Client Centred

Patients valued being consulted in some way about their care. Outstanding nurses were seen by patients as including them in the planning of their care. One participant described how she felt included in the process of deciding whether the

local anaesthetic pump should continue to stay in or be removed. The pump had been inserted at operation and it was now two days post procedure. The two nurses discussed her situation with each other and then with her.

[Two nurses] “... assessed whether they should leave it until the whole lot went through or maybe it was better to take it out and give me something else. They discussed this together as colleagues; the sister on duty, the senior sister and they didn’t exclude me from it because my comments were welcome. So I said, ‘I think that’s great because as far as I can see most of it has been used. ... I think if you can take the tubes out and put a clean dressing on I’ll be a lot more comfortable and then you can give me something else’. I noticed that they consulted about what I should be given. Whether I should be given Pethidine or other tablets. And they asked me which I prefer.” (Pt10 457-570)

Explaining the nature of the illness to patients and their families was identified by participants as being an important nursing activity undertaken by outstanding nurses. They believed the outstanding nurses were not only very knowledgeable in their area of clinical expertise, but typically possessed outstanding communication skills. These factors contributed to the nurse having the ability to impart information in a way that could be understood by patients and families.

“... this is going back to the senior nurse. Because she could spend more time talking to the family and explaining to the family whereas as a satisfactory nurse if the family asks you a question you might be able to bumble you’re way through something or you would barely give an answer, but then you would have to go and find information and do research yourself to explain.” (MHN2 268-274)

“... I haven’t mentioned this before, but very, very good communication and interaction skills with patients and families, being able to impart knowledge and information in a way they can understand and sensitively.” (SW3 154-156).

“...and she was able to talk to ...(pause) ... another thing to being outstanding is being able to explain to the family who are often upset and aren’t too sure about what is going on. Often the doctors are fairly clinical and they give ...(pause)... some pysch (sic) doctors are good but others are quite clinical and families aren’t sure of what is happening. And whereas I

think ... an outstanding nurse are [is] probably more of the patient's advocate, not only to the doctor but the family as well to help understand why a particular person is the way they are." (MHN2 108 115)

Some participants were surprised at the level of concern shown to them in hospital by nurses. Outstanding nurses engaged in what seemed to the participants to be outstanding behaviours such as expressing and showing concern for patients and their family members. One patient explained;

"...the concern for me as a person and concern for not only for me but also my wife and ... always made sure that she [wife] understood what was going on and if she had any questions and I think that was really important as they helped put her mind at rest as well, so for the wider family you know ... to look after her as well as me. That was something I had never experienced because I hadn't been in a hospital for so long." (Pt9 129–135).

He further elaborated,

"... [if] she wasn't looking after me she would always pop in and say 'It was good to see you walking today, how are you feeling? How are you [name]?' When I went back to the same ward for a second time to have the tumours removed she didn't get to look after me but she must have come so many times to say hello and then ... (pause) ... so it was concern for me and my wife's welfare." (Pt9 306–310).

The same patient went on to say that the same nurses who showed concern about their patients also were those who were concerned enough about their knowledge and skills to be undertaking further education.

Concern for the welfare of the patient and family was also identified by a social worker as being part of an outstanding nurse's repertoire of skills. She had worked with a nurse who she described as,

[in the care of patients] *"...very compassionate, very concerned for families as well as patients, very concerned about providing holistic care, identifying problems and really worrying about them, really wanting to change what happens if something goes wrong [asking] 'Was it done well enough?' "* (SW3 148–151).

Ensuring Care Requirements are Met

Individual nurses demonstrated a high standard of patient care. Some of this role involved providing the care that was clearly expected within the scope of nursing practice, which was sometimes overlooked when there was limited time available. However, outstanding nurses seemed able to attend to all care requirements, as one of the nurse participants described, *“She would always go to extra lengths to make them comfortable, and to do everything, like heel care, mouth care, all of those things that sometimes don’t get done.”* (N14 131-134)

Participants described situations where nurses were required to be quite adaptive in their communication with others to ensure that patient care requirements were met. Reflecting on the outstanding nurses she had worked with a colleague described how nurses were sometimes required to interact with the medical practitioner to ensure that appropriate care or interventions were prescribed or carried out.

“... and staffing numbers being kept to a minimum for cost’s sake, so you often find that, you often find they’re in a hospital where the doctor’s off for the weekend, they haven’t prescribed the right medication for the pain control for this patient, and having to manage in the sense of getting hold of the doctor and trying to tell him his job without appearing to do so, and living with the serve that he gives them for disturbing him, and things like that, so they manage a lot of that stuff.” (P3 352-361)

In referring to a situation where another patient was disinclined to co operate with nurses a patient-participant described a situation where the patient had to be encouraged to co operate by two outstanding nurses who were working as team on his ward. The patient was elderly and confused and tried the patience of both room mates and staff.

“Some would get a bit frustrated and cranky with him, and I could understand that. Others ... could be firm but quite humorous saying you know, ‘come on, settle down sweetheart, we are going to do this’. ‘No!’ ‘Don’t cha want to do this’ [participant mimicking response from nurses].

'We are going to do this so come on, you have to help us help you.' (Pt5 447-453)

Outstanding nurses were identified as having the additional skill of monitoring patients while seemingly undertaking routine work such as start of shift assessment and planning. This was seen as something that a nurse less skilled may not be able to undertake or be oblivious to. The requirements of planning and structuring the work load for the shift may be all too consuming for someone with less experience or skill.

"Monitoring I think, because everyone plans, everyone has got to plan, time manage patient loads, to write down their time plan, eight o'clock medications, obs, and so on. This person goes above that and the only thing I can think of is that they are also monitoring other things in the background, simultaneously, paralleling the care." (N2 169-172)

Managing the Unit

Nurses who fulfilled the role of the shift coordinator were often identified by nurses and other health professionals as being outstanding nurses. The role required that the nurse manage the unit on that particular shift, and staff other than nurses also identified the more outstanding nurses as being important to them in how they were able to carry out their own roles on the ward/unit. That is, a detailed handover from the ward coordinator meant that the health professional could go directly to treat the patient, bypassing the more time consuming task of obtaining information from the patient's case notes. There were many accounts of how outstanding nurses managed the unit from different health professionals and nurses as this role seemed to be immensely appreciated.

"It's like you know the ward coordinator that knows all the patients. I mean that always impresses me, because the ward coordinators change so frequently, and yet they know what's going on with every patient, and what's the social worker side of things, and what's the medication, what the doctors are doing ..." (P5 272-276).

“She communicates well with the nurses and the doctors and we have a number of doctors working in the area. She is always professionally dressed, lovely personality and she is always very aware of what is going on in the whole department [Accident and Emergency] and around her and if things seem to be slowing down,[ask] ‘why isn’t this patient moving on?’ and following it through. She is a very good coordinator and a very good triage nurse as well and she is forever learning, which we all have to do these day.” (N10 137-147)

“... and this person automatically seems to be able to step into the role even though they are not the senior there, but the delegator and the organiser and just gets everyone to become unflappable and that ability to personify calmness when everything is still being organised and directed.”(N15 105-109)

Outstanding nurses maintained a dynamic awareness of the situation on the ward based on assembling data from the environment and thinking ahead about what might happen next. As explained by one participant,

“...again, she does all that assessment. If you watch ... from the moment she’s walking on she’s sizing up her environment she is ... (pause) ... even before she’s got to the nurses’ station she’s got a bit of an idea about what lies ahead for the ward. She is checking with all the relevant people, even before handover sometimes you can see it happening. She’s sizing up where issues are, where issues aren’t. As with the good nurse she’ll take some leadership roles with handover. Often after the taped handover will then give directions as to what’s happening.” (N7 160-167)

The above examples are given by nurse participants. However, comments were also made by other health professionals about outstanding nurses co ordination skills. One participant, reflected on one nurse who she described as being a good planner, who had processes in place early so that patients’ discharges went smoothly. *“She was a good planner. Like knew which patients were going home when, and had it structured that their discharges were smooth with her at the helm”* (OT2 103-105). This particular nurse was described as being a good communicator who gave plenty of notice to team members about impending discharges so that patients being discharged could

be reviewed in a timely manner avoiding the need to do time consuming visits post discharge.

Theme Two: Modelling Exemplary Professional Behaviours

This second major theme was generated from the participants' views about values displayed by outstanding nurses. In addition to identifying professional values participants identified a number of instrumental values (moral and competence values) in outstanding nurses. Participants described broad modes of conduct which Rokeach (1973) refers to as instrumental values. The sub themes are: Valuing Nursing, Showing Compassion, Respecting Others and Being Reliable.

Valuing Nursing

Outstanding nurses demonstrated to participants that they valued nursing. In particular that the nurse herself perceived that nursing had intrinsic value and was important for the well being of the patient.

Interviewer: "So would you call H fairly well outstanding."

"Yes. I would say H was probably in her forties and somebody who had obviously learnt that the practicalities of nursing is really about people not just what you learn in books, and the chores but she actually, like R there really is, they are there for you. What I am doing is really important and I want you to be comfortable and happy and recover quickly." (Pt10 187-193)

A positive attitude toward patient care requirements was seen as being an important attribute. The enthusiastic nurse's actions in addressing the patient's needs and seeking out health professionals to progress the holistic care of the patient was interpreted as being positive in attitude. Outstanding nurses were identified as having a positive attitude toward patient care. This attitude can be seen by the example below, where one nurse reflected on an outstanding colleague who demonstrated a high degree of enthusiasm about patient care and her engagement with other professionals.

“I’ve also come across ones that you walk into the ward and they’re already for you to say, ‘look, we’ve already showered this and done this, when can I grab you to come in...’ and you think, wow, they’re really interested in the patient’s care, they’re really focussed, and they’ve got a positive attitude.” (P2 169- 173)

One participant stated that the patients were well cared for by a particular outstanding nurse. She also described the patients as happy when they knew that the nurse was allocated to them for the shift. In response to a general question about the outstanding nurse’s attitude the informant responded, *“She loves nursing and she loves being there and she loves doing what she is doing.”* (N8 174-175).

Showing Compassion

Being compassionate was described as another attribute of outstanding nurses, and this was explained as being gentle and understanding about what the patient was experiencing. One patient described her experience of witnessing compassion as she was going into the operating room suite and feeling particularly vulnerable. Her description below seems to reflect both compassion and empathy.

“Well the first one came to mind particularly was the nursing sister in surgery who was there when I went into the theatre. Didn’t say an awful lot but she just held eye contact with me and she did something that for me was worth more than a thousand words. She just held my hand and up to that point I didn’t think I was nervous, but as they wheeled me into the theatre and as you are actually there you feel very vulnerable and this nurse, just, she was obviously very tuned in and very empathic and that was what stood out. And I didn’t actually realise, but I was crying. The tears I could just feel them running down my eyes, no sound and she just held my hand and said you are going to be just fine and squeezed my hand and that was just so beautiful. It spoke masses you know and it said to me she was totally professional. She understood even when the patient doesn’t necessarily understand all the things that they are going to go through. The fear, the vulnerability, she was just so gentle and compassionate and empathic, and it stayed with me and I never saw her again, her name was [name].” Pt10(48-65)

Respecting Others

Being respectful in manner to others, including patients and staff, was identified as another attribute of outstanding nurses. The respect for others was

perceptible in routine engagement with others and particularly noticeable when the situation might be deemed as difficult. This ability to maintain respect for others no matter the circumstances in turn earned the respect of others.

“Respectful in her manner full stop, so with staff, with patients. ... Um, again very respectful in meetings, able to differentiate between the sort of personal problems and the um, the public issues if you like and to engage on those in a ... (pause)... you know in a very helpful manner you know looking for solutions. Very appropriate with multidisciplinary teams and ... had respectful relationships with the medico’s rather than a subservient relationship which I think is really important.” (SW2 257-270)

One participant described a situation on the ward where a nurse was underperforming significantly, resulting in medication errors and errors of omission occurring. The outstanding nurse was able to demonstrate the appropriate management of the situation whereby the underperforming nurse was treated with respect and able to leave in a dignified manner, preventing as the informant said “ a witch hunt”, “... *It wasn’t just one person who respects her it’s just everybody. She just shines in terms of her ... I think it’s her ability to respect people.*” (N7 579-582).

One informant talked about a nurse who showed a great deal of respect to a particular patient,

“ ... he was covered in psoriasis from head to foot and had to undergo all these baths and skin scrapings But she had respect for him ... she would hold his hand and talk to him like he was really important. I suppose that was it, she could focus on the person.” (N5 239-248)

The nurse went on to talk about how this ability to focus on the individual was very important as this could make one feel that one is the most important person to them at that moment. This was captured in descriptions of outstanding nurses being generous of themselves toward others, “...*a giving...*” as one of the participants explained.

“... so she sees a need and in a very soft and gentle manner but firm, a mixture of strength and gentleness you know, is able to support. And in this particular situation there was a team who was having gigantic ethical dilemmas about the care of a patient. So on her own initiative she organised a debriefing session for the team after hours, which is magnanimous. Which is a great giving and an acknowledgement that someone is hurting and that I can actually do something about that.” (D1 302-308)

Another participant described the acts of an outstanding nurse toward her fellow colleague in terms of generosity and gift giving.

“She will tell you if you boo booed and you knew exactly where you stood at the same time when I was leaving, she did all the right things. She bought a beautiful present and there were no holds barred, she did all the right things. It was a very warm farewell, a kiss, a thank you and a hug, and great to work with you, sorry you have to go.” (N2 238 – 245)

A patient gave an example of the outstanding nurses being obliging and helpful by volunteering assistance and said “... Well, I suppose you could say they go out of their way to help you.” (Pt2 193-194), and then later in the interview said “Oh, just general, you know, just saying if you, ... (pause) ... they come and ask you if you want a painkiller or something like that, they seem to be ... you didn’t have to ask for it, they’d come and ask you if you wanted a Panadol or something, or what’s that other stronger one?” (Pt2 389-392)

Being Reliable

Being dependable was valued particular by patients. One participant found that the nurse that he thought was outstanding could be relied upon consistently. This fostered a feeling of trust in the nurse.

“ ... you know, she’d come and talk to you, and some of the other nurses come and talk and you say ‘What [did] you want?’ and then they get sidetracked and forget about you, but she didn’t. She did it all the time, even though if she was away for a quarter of an hour, she’d come back with what you wanted, you know, which I thought was pretty good. Well, you could, more or less say, you can ask her something, and it would be done for you, you know, as quick as she can do it.” (Pt2 103-120)

Participants also valued nurses who were conscientious about attending to the details of patient care. This thoroughness was portrayed by an outstanding nurse in the following way,

“Everyone is taught the same things; she will be the person who chases up the wound management plan because there is supposed to be one for everyone across the board. This is a standard or chase up IV fluids so that it doesn’t run out at night time.” (N2 197-201)

One aspect of reliability was shown in the way nurses demonstrated perseverance. When initial goals weren’t achieved or patients were not responsive to the endeavours of the outstanding nurse then the nurse would persevere. One nurse described outstanding nurses in the following way,

“... they repeatedly get knocked back but they’d still be ... (pause) ... and they might do really well with a patient for a week and the patient will have an episode and refuse everything under the sun and be totally non thankful about what has happened. But, you know they persevered and they keep going.” (MHN2 480-483)

Perseverance was also shown in a nurse’s ability to persevere with her patient to achieve patient care outcomes,

“She’d like write out, I mean I got so bad that she wrote out a list of rules, whatever my problem, she would like, ‘go read the rules then come to me, go read the list then come to me.’ ” (MHPt3 88-90)

Theme Three: Balancing the Personal and Professional

Many participants identified behaviours which can be described as competence values and the ability to bring to the workplace positive personality attributes.

Bringing personal attributes into their professional lives contributed to making the workplace an enjoyable place to be. There were a number of subthemes that evolved from the data analysis to help explain the nature of these positive attributes and how these were experienced in the workplace in outstanding nurses’ professional roles.

Being Happy at Work

Many participants identified that it was common in nurses who were outstanding to have a happy demeanour in the workplace. This happy demeanour was also reflected by their enthusiasm and the energetic way they went about their work. This indicated to the participants that the nurse was happy to be at work, rather than a more general statement about the nurses' state of mind.

A number of participants described the outstanding nurse in their vignette and what they noticed about that individual in the following way, “... *I have a couple in mind, but you just, like, you walk onto the ward in the morning and they always look happy, they'll always greet you... .*” (P2 222 – 223)

Some participants suggested that in the nurses' personal lives there may have been cause for unhappiness, however this was not acted out in the workplace, nor did it dominate the issues at work. In the following participant example the nurse referred to had previously disclosed information about her husband.

“...to be happy to be out there working. Even if things may not be going so good outside [out of the work environment]. This particular girl (registered nurse) was thinking of her husband doing post graduate study which she had to work an extra day [for] and hoped to get into teaching. And for a whole year [he] was looking for a job and couldn't get one and yet she never brought that to work ... It wasn't like a big weight on her shoulder at work.” (N1 234 – 241)

One participant suggested that being happy at work may be a “...*portrayed personality*”. When asked what was meant by this statement responded, “*In the sense that when they are at work ... I am not sure out of work but at work, they are very happy people and they are just not unhappy to be there*” (MHN2 530 – 532). The participant was unclear about what “portrayed personality” meant or how it was exhibited beyond saying that what ever was happening outside of work bore no influence on the nurse's performance at work.

Participants observed that nurses who they thought were outstanding demonstrated enthusiasm about what they were doing at the time and that this was not necessarily evident in other nurses.

“Enthusiastic about what they did. Felt that what they did was more than just nurses ... they didn’t see nursing as just a job. They saw it as a dedication a calling you know, and I discussed that with a couple of them.” (Pt10, 509-512)

The enthusiasm the nurses displayed could be directed towards their work or patients in general or as stated below by a participant to some aspect about them and their care.

“Whereas there were other nurses who would come in and they would say, because I was there for about two and a half weeks, and others would come in and say, ‘Oh, a dressing, great’ ” or “ ‘I haven’t done a dressing like this for ages, I can’t wait to get stuck into it’. They had a completely different attitude and even though they may not have been really sure because it was the first time they had ... they would look at it and just copy it.” (Pt 9 78-84)

Some of the participants talked about outstanding nurses being energy efficient or energetic. By this the nurse was seen to do things promptly and quickly without a fuss. As one participant said *“they just get on and do it”* (P6 369). Having a lot of energy was also seen as being necessary to cope with patients who demanded or required a lot of input to manage. And indeed, nurses who did not have a high level of energy were seen as not being able to sustain care in demanding and difficult situations.

“Sometimes the patient themselves was a very difficult individual to manage. Sometimes violent, sometimes just so debilitated that it took a lot of energy to actually cope with that person, doing whatever you had to do was just so draining energy wise that ..um ..everybody got tired dealing with them. But the outstanding nurse really, ... (pause) ... would just, whether it was instinct or training know how to handle the person”(OT1 146 152).

Being Genuine

A number of participants identified that a nurse's ability to convey a sincere interest in the patient or staff member was an attribute of outstanding nurses.

"... not just walking by and asking how are you and not hearing the answer, but actually taking the time to hear the answer and say 'How's your son? or How's your husband after that incident?' or whatever. Just that sort of whole person, well rounded person, I guess it wouldn't have mattered what path she had chosen she would have been exceptional I think." (N15 147 – 153)

".... somebody that is competent and looks competent and is confident and the outstanding nurses are the people who can do that plus do what I consider to be old traditional style nursing ... A particular example that stood out to me was an old fellow who's in his eighties or something and having a placement dilemma, getting to the point where he's not independent anymore, and it was just before Christmas and so he was anxious.....and this nurse was giving this guy a cuddle and it almost brought a tear to my eye. ... and she was just great and like she really meant it." (P6 85 – 101)

Showing Personal Warmth

The observed behaviours of nurses towards other patients also impacted upon patients' perceptions about nurses. Showing personal warmth toward patients was seen as being an attribute of outstanding nurses and this was described by one participant in the following way;

"...the thing that stood out ... she had a special warmth. There was this elderly lady in the bed next to me, whose name was [name given] ... she was ... 92 and had taken quite a heavy fall and had broken her leg. She also had quite severe Alzheimer's... and when B was on duty this lady didn't like being called Annie which was her name, she liked for some unknown reason to be called N. Annie would be flailing in pain with crying a bit, constantly confused and everything and when B was on duty ... she would come in and cuddle her and console her, tremendously and make the lady comfortable, rub her and ... it's so nice to see a nurse be able to do that, to console a patient and make her comfortable and that lady ... was able to understand, because she always relaxed after Beth spoke to her." (Pt7 140 – 157)

Being Well Groomed

The nurse's presentation influenced perceptions about nurses. This reflected the expectation among study participants that nurses will 'look the part'. Traditional attire of uniform and 'duty shoes' was/is still an expectation. If a nurse was able to

attend to the detail of an appropriate standard of dress then it cultivated an image of a person able to attend to the care requirements of individual patients. A patient participant described how some nurses did not present well compared to the nurse who was outstanding.

“Well she was very unassuming, ... had a pleasant manner, looked well groomed, ... some of the others didn’t take enough care of their appearance, a bit scruffy around the edges ... several of them seemed to come in with their joggers and they looked like they were the same joggers they went to the beach in ... they didn’t take that extra degree of care, separate a pair out to wear to work.” (Pt9 276 – 283)

Theme Four: Managing Self and Others

The outstanding nurses exhibited self management skills. They managed their emotions well and therefore were not seen to panic and become poor managers in trying situations. Outstanding nurses were also renowned for the support that they offered individuals or were seen to give others support.

Being in control of self

Being in control of one’s self or in command of self was seen as an attribute of outstanding nurses. This was often described as being on an “even keel.” An even keel meant that these nurses were difficult to destabilise. They remained in control of their emotions and therefore were able to perform well in very stressful circumstances. I asked one of the participants to describe an outstanding nurse, in particular how they went about their work. Her response follows,

“I think, depending on what area I’m working in, I can picture different nurses that excel. I think the ability to stay on an even keel is an outstanding, ... (pause). Like there’s some wards I’ve worked in where emergency situations occurred on regular and varying occurrence, and they then, they just handled it, everything just ran really smoothly, and they were able to sort of like take that control, so there’s a confidence in their skills and their ability. The, ...(pause) ... I suppose, they, they’re got to have covered all the previous outstanding, I mean, the “what-makes-a-good-nurse” sort of skills, in that communication, and whether it’s, I suppose, yeah, the bedside manner

I suppose you call it, with the patients, but it's that ability not, you know, you almost like, you can't knock them off [their] keel,” (P5 154-167)

The outstanding nurses were self managers. They exhibited a great deal of self control in at times trying circumstances. This self management in outstanding nurses was exhibited in other ways. Participants commented on the fact that outstanding nurses didn't bring the details of their personal lives to the workplace. The nurses while like anyone else, may have difficulties in their personal lives didn't allow this to dominate their working time. This is illustrated by one participant who said; “ ... *They [the outstanding nurses on the ward] ... have all had personal problems but they don't dominate the issues at work*” (N6 397-399). The ability to not let one's personal life intrude into the work environment was further identified in part of the interview I had with one nurse participant;

“I know sometimes, (pause) she is a single parent, and I know she has had sad days, I know her husband in particular had taken their son back interstate and she does ... and she'll sometimes in coffee break you will know. But it doesn't really seem to affect her nursing ability. Her other life is quite difficult. She has to juggle babysitters, school and children and so I think that this particular nurse life isn't always very easy for her. ”

I: “So, what do you think it is about her that it doesn't carry over into the work situation, so yes you know about it but it is not there working with you so to speak? ”

*“I think she has probably learnt to do that, because I think she is probably a very compassionate person that has learnt difficulties in life and doesn't sort of,umm.... it is not her work fellows fault or not her patients fault you know, she is here now and that's her life and that is difficult. And that gives her an edge as it gives her compassion, it gives her understanding, it gives her all those skills that she probably.....and she puts those to good use in the workplace but she doesn't let it cloud her workday or anybody else's”.
(N8 177-200)*

Being Calm and Coping

Outstanding nurses adopted a demeanour of calmness. This calmness was particularly self evident where the work was at times heavy and stressful. On a

rehabilitation ward the outstanding nurse “.. *was always perfectly serene. She could calm down somebody who was upset, help them, or [someone] out of control*” (P4 107-109). Other participants also commented on outstanding nurses’ calming influence.

“I am sure a lot of times she was [stressed]. She never appeared to me that she was panicking or worrying about something that had happened, she just seemed to be able to run with it and deal with it and nothing ...but, nothing seemed to trouble her.” (MHN2 356-375)

“I think it is more than just a leadership skill, I think it is a personality type as well and I suspect that was probably why she was picked for the job particularly for that ward, because it wasn’t an easy ward to work. So it needed somebody at the top who could calm everything down. Because on a ward like that you only need one thing to go wrong and if you have got the wrong people around, the thing escalates so you need someone who could calm them down.” (OT1 390-396)

Nurses identified as outstanding were described as being able to respond to whatever the work situation presented in a way that demonstrated their resilience. The nurses described as outstanding were when confronted with situations that were not the normal every day events of the ward were able to respond to the circumstances in a way that suggested that they were not overwhelmed by the events.

“She never appeared to me that she was panicking or worrying about something that had happened, she just seemed to be able to run with it and deal with it and nothing ...but, nothing seemed to trouble her. ... If events happened then she would do “y”. It just seemed to come, ...(pause)... she just stepped through.” (MHN2 356-376)

Outstanding nurses were seen to respond to problems and issues on the ward without fuss. They remained calm and responded without alarm to situations as they arose.

“But without thinking they were in a drama, they never dramatised. They were that... especially because there were the ones that dramatised, not knowingly, the nurses, but they would, I felt I could always, and I would operate that you could go to them with ‘this is happening now, this is, you

know, a person's escaped (sic) or they've... '...(pause) ... there'd be no drama, they'd just ... (pause) ... action would happen." (P1 279-284)

Not only were outstanding nurses able to remain calm but also demonstrated that the situation was about to be brought under control or that they had control of the high pressure situation. They could also adopt a suitable forceful manner without undermining the role of other team members. This had a calming and settling influence on the team members. Participants described outstanding nurses in the following way,

"... the one nurse I am thinking of is an Irish fellow actually. He comes on, he is dressed neat very casual, he is in his late forties and he will come to work and the first thing he will do is go and make a cup of coffee and say good morning to everyone and chat about anything other than nursing or hospital business. If the ward is chaotic, on a day shift and particularly come in and night shift are ripping their hair out dying to get home, he will still come in and have a cup of coffee see how things are going and then say to people... say leave it, day shift coming on we'll handle it, let's go and have a cup of coffee and go and have handover. You guys can go on home because you're tired and we'll look after it. It is in that sort of tone of voice. It is not an issue, it is never an issue." (MHN1 125-138)

"The fact that at all times she could maintain her calmness despite the complexity. Never saw her looking stressed." (P4 260-262)

"... um.... Interesting ah, just reflecting on those outstanding nurses, they would, it was very rare that you would see them in any other capacity other than competent and calm and clear." (SW2 426 – 429)

In reflecting on outstanding nurses she had worked with, one nurse participant said,

"I think they certainly come across when you look at them you think yes they have got control they know what is going on and I think that is not being flustered, not whinging too much about what is not right about the system because that is very easy do. They tend to thrive in face of adversity rather than get bogged down" (N6 274-279)

Another reflection came from a former patient on a mental health unit. She described outstanding nurses as being able to cope with the pressure of disruptive behaviour from other patients described as a small emergency,

“...and I notice that whenever something would happen, there would be a small emergency that they all handled that really well. They took control of the situation and they didn’t lose their nerve. And so you know I admired them for that and they weren’t awful to the person that was causing problems. They spoke to them in a steady voice” (MHPt1 250-256)

Supporting Others

Outstanding nurses were seen to have the ability to build the team on the ward and to support staff. The leaders at the ward and unit level were seen to be supportive of staff no matter the circumstances. The first example below is from a nurse who described the outstanding nurse as not being in a formally appointed leadership role on the ward. The situation involved a nurse trained overseas who had made medication and nursing treatment errors.

“ She encouraged us to make negative reports if they were required but she I think in her own way ... (pause) ... she quietly reminded every staff member to be clear in their observations of her, but to be respectful toward her. It wasn’t a witch hunt. Looking back on how the senior nurse managed it, was the way she managed also the other staff around this woman, because ... ummm ... she was certainly wanting clear answers. She was certainly wanting an outcome ... she was wanting it to be an outcome that didn’t destroy someone in the process. ... I think a lot of nurses learnt from that process. Were able to look, ... (pause) ... made some of the nurses stop and think about this person. Because there were quite a few who were very critical of her, [saying]... ‘Oh this is really difficult, this is a real language issue, isn’t it’. Not that this is a bad person, without caring ... oh, we’ll get her off the ward. But not to the point where we were molly codling this nurse. I think what impressed was that she managed to keep very private what was with that other nurse in that respect. But also managed to get the other nurses mindful of what was going on but really guiding them in the process about how they handled the situation.” (N7 526-544)

Outstanding nurses were seen to support their staff; usually as a clinical nurse specialist or a nurse manager. One participant described an outstanding nurse as being firstly, the right person for the job, and secondly, someone who came to the defence of staff, *“She defended her nurses against attack from all quarters. She was imminently patient even with those who were not very competent.” (OT 124 – 244)*

Another nurse described an incident on the ward where the nurse manager had supported a staff member.

“... so that person goes into bat or if it isn't the person's fault they go and say that this is not her fault. For example, one patient went down to theatre without the TED stockings on. The patient came in late at night and were [sic] the first off the list in the morning. The girl took the patient down to the holding bay, the anaesthetist happened to be there waiting for the patient arriving... 'and why isn't the TED stockings on' and tore strips off the girl. She said, 'I have ordered them, am coming down with them as soon as have them, but the pharmacy doesn't open until 8 o'clock'. 'Not good enough'. The girl came up crying and the Nurse Manager said 'That's it.' ... down she went into my theatre and said 'You do not speak to my nurses ... and he came up and apologised. There was no way that that girl could get TED stockings without going to the pharmacy that is the way the system is set up. So much respect for that Nurse Manager to do that for her staff and don't wait until the next day or the day after, just nip it in the bud there and then. So you do need, also that girl was one of [our] best nurses but that would have destroyed her confidence for a long time.” (N1 726-752)

In an earlier example (see creating a culture of safety) the poor behaviour of other health professionals was also dealt with immediately.

Being approachable was considered to be important by a number of participants. The patients did not see this as being an attribute of note as much as the nurses and other professional groups did. Some professional groups were reliant to some degree on the information from the nurse about the patients as a way of assisting them with their own treatment plan for the patient. Therefore the more easily the nurse could be approached for information or assistance the easier it was for the health professional involved to undertake their activities with the patient. One health professional stated that if the nurse was approachable and provided information about the patients then that bypassed the time consuming task of reading the patients case notes for their history and changes to condition and treatment plan. One participant commenting on an outstanding nurse explained:

“They often changed who was at the helm but this particular one was always very approachable. She was always very friendly, organised, respectful, didn’t backstab the medical staff, she wasn’t defensive of what the medical staff were asking.”(OT2 126 – 129)

This description above suggests that the outstanding nurse spoken of here was confident in her own approach to all staff. Nursing staff also found that outstanding nurses were very approachable and therefore any difficulties that were encountered could be openly discussed and therefore not hidden.

“...still you could go to him and you could say, ‘I don’t know, I don’t understand you know, there is something wrong with the patient and I’m not sure what’s happened’. Or you could say, ‘look I think I have done something wrong here you know’. Or, ‘I don’t think medications have been given’ and he would say to you, ‘this is not a problem we can always sort this out’, and he would go through the whole procedure about how you go about sorting it out... .”(MHN3 76 – 82)

Only one informant identified an outstanding nurse as not being approachable, “...
but not approachable. That is the only difference, you don’t feel you can approach her, you feel like you are a nuisance, not of value of her time. I felt brushed off a couple of times I tried to approach her.”(N2 272-275)

Nurses who performed at a higher level were seen to be very attentive. This was contrasted with nurses who paid less attention to detail, whether the reason for nurse patient interaction was for routine care or for procedures, as in the examples given by patients below.

“Sometime[s] even when I want to go and have a shower, she always take all the towels and whatever things and put in the bathroom and she comes and helps me. But some nurses they said ‘here all of the things, just go’.(Pt8 68-70).

“It was a bit of different treatment you see. I hadn’t had an op. I was just given all this blood. But I think the care was better in the M than it was done there.

I: “So what was the difference?”

“I think when they were giving me the blood I think it might have been the procedures. They stuck with you more, the nurses stayed with you longer at the M.”(Pt1 358-367)

Another participant observed that an outstanding nurse was in attendance frequently to meet the needs of another patient,

“ ... But she would come to A constantly, constantly. When she was on shift and have the curtains around and be doing dressings. I would always see the tray in there, pain medications she would give her the injections, I would constantly see that. She was constantly at A, with A and consoling her. She was a very, very sick lady. ” (Pt7 190 – 200)

Being Visible

Outstanding nurses were identified by the patients as being very attentive and constantly in attendance at the bedside, or at least appearing regularly and being solicitous about the patients needs. Nurses saw visibility as having more meaning than being physically present and seen. As one participant explained about nurses who weren't highly visible;

[invisibility] *“... it's not always [about] being in the pan room or not being seen ... (pause)... it's not being seen to be responsible for anything. It's this subtle way of being able to get out of responsibility, passing the buck sideways or forwards or an inappropriate passing it upwards when that person could have acted. 'Oh yes, but I told so and so' when you could have done something or initiated something yourself, and again invisibility is an issue of not being proactive and not taking that accountability.” (N7 285-291)*

Being visible meant that the nurse took responsibility on the ward on different levels; for policy development, attending and speaking at meetings and dealing with the problems.

Visibility was also described in terms of body language. One participant commented that *“...the nurse makes a lot more eye contact with me. She doesn't hide, she's very visible.” (P1 581-582)*

The outstanding nurses were identified by one patient as checking on her regularly and by another as observing that the nurse was constantly being seen by him. This suggests that higher performing nurses were in the patients' presence more as well as attending thoroughly to patient requirements.

I: "Was there anyone who was really outstanding who you thought was ... "

Yeah, actually one nurse Because actually she even at night time she comes always to check me and whether she asking you want anything just water, ice whatever you want. And if I want to go to the toilet some nurses said "Oh no you don't need to go to the toilet."

I: " So what did she actually do, how did she go about ... "

"Quickly and always around us... two nurses actually I really loved them because one nurse, she is a bit older as well but she is lovely. My sister was with me for five nights because I couldn't do anything. That nurse, I don't know that one, she comes all the time and check me, [asks] "Are you OK?, The pillows are OK? You won't be tired[with] your pillow?" Always come and check me because I couldn't sleep those nights, "... you want Panadol, Any pain?" Always come and ask me if you want to go to the toilet, if you want to change the bag if you are uncomfortable, just let me know. She is always come and ask me, I had that nurse three or four nights. I was happy when I saw her, I went oh this is the nurse I want this night is going to be very good, yeah, when I saw her, ... I don't know her name." (Pt8 40 – 128)

" ... and things like that, and she was more or less in charge. I think she was the charge nurse, sometimes the nurse that was in charge of the ward would be out with the office part a lot of the time, and you'd only get her on special times, but this one seemed to be there all of the time, moving around." (Pt2 146 – 150).

"She was just always there. She wouldn't be there ... like with the motherly ones they got kind of annoying ... Sure it is great to be taken care of and stuff but, and she was firm, like she wouldn't let me get away with anything." (MHPt3 45-49).

Being Available

Outstanding nurses demonstrated that they were available to assist patients and staff. One participant described this in the following way,

I: “Was there anyone who was really outstanding, ?”

“... that nurse she is always around the patient, when we press the bell she is here very quickly. Because some nurse we have to ring the bell several times to come, and I really appreciate that” (Pt8 38 - 57)

Another participant described an outstanding nurse who was often the shift coordinator,

“... she is always looking out to see what else she can do and who she can help, ‘Are you right?’. She is always checking up to make sure that we are managing our patient load, she just does it very, very well.” (N8 201 – 216)

A participant described a new graduate nurse as outstanding and commented on her availability to assist others with their patients, *“This particular nurse ... a readiness to assist and support the coordinator and take [a] leadership role for the coordinator (N7 448 – 451).* The participant stated that where she worked the other nurses knew who was available to assist them and therefore who they could go to for help.

Theme Five: Forming Personal and Therapeutic Relationships

Forming a personal relationship with patients was seen as an attribute of outstanding nurses. Ten participants gave examples of outstanding nurses engaging in relationships which were more personal than simple conversations about immediate requirements or transacting information. These more personal relationships were of benefit to the patients. One of the participants described how the relationship between the nurse and the patient and family member had assisted the patient who had a poor prognosis and also assisted the team to better manage the situation.

“This was a fairly stressful time for the nurse and for the family themselves ... em... and it was a youngish man who had a very unpleasant malignancy and ... we had to go and talk to him One of the nurses that went with us had actually formed a relationship with this guy and his daughter. It was really the way she handled you know, that sort of stressful bit and provided support. In the process of talking him through this she was involved in the process as well already having formed that bond. ”(D2 111 – 123)

In essence, the “breaking of bad news” was made easier for all the people involved because of the relationship the nurse had developed with the patient. The relationship then became highly therapeutic for the patient and his daughter by the way the nurse interacted with the patient:

“... and he still had a close relationship with his daughter and whether the nurse had some sort of identification through his daughter or something I don't know actually I wasn't able to observe that but she really had a personal relationship with him. It wasn't one of I'm here and you're there. I'm the boss and you're the subordinate... .” (D2 166 - 171)

A patient recounted how a nurse was more personal in her approach toward him when he was having difficulty sleeping in hospital and that this skilful approach had been helpful during a difficult time during his hospitalisation.

“There was one night I remember in there where I couldn't sleep, K ... she said 'I am going to have my break in 10 minutes, I will come back and have a cup of tea with you. What do you want?' And she gave up her break and sat and talked to me. And then she talked to me about what I had done and where I had been. ... knew to be able to talk, get you to talk about your past life and comfortable to be able to talk about your past life. ... knew how to get you through those hurdles.” (Pt9 182 – 191)

Using Situationally Appropriate Skills

Participants gave examples of incidences where they observed outstanding nurses changing the way they communicated with people according to how the individual's personal situation was at the time or communicating in a way that mirrored the person in some way. The nurses' ability to adapt to the individual so that their communication style changed was perceived to be a positive and useful skill. Two examples of this was described in the following way,

“... she was very friendly and she just seemed able to talk appropriately and change her tone for all different people. For the patients that required a happy sort of person, then she might talk to that person at one stage and talk to a person next door or at the other end of the lounge room and this person would be quite serious and very upset about something and then she would be able to go talk to someone’s family about issues.” (MHN2 128 – 134)

“... I mean, the ward I work [on] now, there’s actually a couple of excellent nurses, and thinking about their characteristics, and what they do, it’s that ability to, like they’re almost different with each patient, so they adapt to the person they’re looking after, even if they’re in the next bed, and they’ve just gone straight from one to the other, you see a slight change in how they approach the person. There’s some that you’re having a laugh with, and there’s some there’s quiet respect, and you know, it’s an elderly lady that doesn’t want to be having a laugh and a bit of a joke whereas the gentlemen in the bed the other side needs a bit of jolly up, so it’s that adaptability.” (P5 346 – 358).

Demonstrating Exemplary Communication

Nurses who were able to communicate effectively were seen to have a number of key behaviours. An important behaviour was perceived to be one where nurses followed the convention of greeting people on first encounter and introducing themselves. The examples below illustrate this aspect of the communication skills of outstanding nurses,

“I watched him and this man would go into patients and he’d say, ‘Good morning Kristina. How are you?’ ... he would do the whole thing, ‘I am looking after you today, we are having a bit of a problem’, you know he would explain the whole thing” (MHN3 60 - 64)

“... she is an incredible lady... (pause) ... including allied health not just nurses, she also wanted to know how we were as well. There is always a greeting during the day, or whenever she first comes in. ... and it is often a chat” (OT1 332 – 335)

“I guess, I’ve got a couple in mind, but you just, like, you walk onto the ward in the morning and they always look happy, they’ll always greet you, they’ll always have time to, say, have a quick chat about how your weekend was, ask how you are, they don’t seem rushed or as if they don’t have time for you or as if they don’t have time for their patients.” (P2 222-226)

Some nurses were perceived to have no difficulty with communication. There seemed to be an easiness about communicating with patients and other health

professionals. The following quote explains:, “They seem to have this manner of talking to the patients and it just seems to come second nature to them. They are able to interact really well, and you see other people who struggle to talk to a patient.” (MHN2 357 – 360)

Their good communication skills also encouraged others to communicate. This was described in terms of the nurse’s open style of communication and the transparent way in which the nurse approached her work.

“She was just someone who was pretty open about things you know and straightforward, doesn’t play games you know. ‘OK, we have a problem let’s sort it out’. There is no game playing no power play basically which is very good. You know you can talk to this person and get everything sorted out and that sort of thing. You can work with people like that.” (SW1 134-139)

The ability of the nurse to give clear explanations to patients about their care was considered to be important by a number of participants. One participant said, *“Well, when you would go and help her with pressure care or help her do something, she would always explain things to the patient”* (N14 98 - 99). A patient described an encounter with an outstanding nurse who took time to explain, ... *“She was wonderful, she took my blood pressure and temperature and explained to me that I couldn’t have anything to eat or drink and I understood...”*(Pt10 162 – 164). Patients in the study suggested that an important aspect of clarifying information was the role of translator of medical staff communication. Two participants described this role in the following ways and both indicated that the medical translator role for them was an important aspect of their care.

“ As I said, letting you know what your progress is and how long you can anticipate being there because after the doctors have done their rounds and the specialists have done their rounds ...err ... the doctors and specialist being doctors they sort of ... (pause)... three or four look at you and go ummm...ummm...umm.. mumble mumble and say ‘Okay, see you’. I think it is important after the so called experts have examined you that the nurse can

come back to you and say “The doctor is quite pleased with your progress. We will just keep things going as they are.” And if that doesn’t happen you are left there thinking, What was that all about? Where am I going?” (Pt5 345-359).

“... a lot of time, a doctor will just go duh duh duh, and not actually communicate to you what he is actually doing. So you have to ask the nurse because the nurse seems to know what is going on. But the doctor goes give him this, give him this, give him this and walks off and does something else. Whereas people want to know what is going on with them, why are you giving me that, and I think in a lot of cases the nurses know, or are able to tell you. I say the doctor knows but the nurse is more likely and maybe have more time to tell you exactly what is going [on], what we are doing and this is why we are doing it.” (Pt 6 120 – 130)

Participants thought that it was necessary to have a sense of humour in nursing. One explained that although it wasn’t necessary to be a stand up comedian to be a nurse, humour was necessary for the nurse to see the *“lighter side of things”* (P5 550) particularly as a way of dealing with a stressful occupation. Humour was an asset to outstanding nurses, although it may have been dependent on the situation and the particular patient. For example,

“... had a sense of humour, definitely. Could see the bigger picture, just in everything, you know? Certainly made everything a bit more fun, whether it was fun with the patient, like just being silly, making some game. ... had that ability to go in there and make a joke, say about an amputation ‘that was perfect’. So, you would never say it was not nice, or whatever.” (P1 222)

Another example from a participant describes how one nurse had used self deprecation to elicit the co operation of the patient. For example,

“... and say, you know how I’m so obsessed with this, or they make it into a joke, you know, ... the one that makes the patient feel better is the one that makes a bit of a joke, and says “you know that I’m obsessed with this, can you just...” and it’ll work.” (P2 475-478)

Outstanding nurses were also seen as effective communicators and managers in what can be described as difficult situations.

“This man this day was very deaf, poor vision and had a daughter and son who were fairly not interfering but dominating, and she handled the situation

well in that she was able to...(pause)... , I don't know. She made the situation so the man the patient himself could be heard and she picked up on the vibes I suppose of what was going on. She remained very patient throughout; never got short with them and it is difficult to say how.” (OT2 123-128)

Being willing to listen to patients and staff was part of good communication. For example,

“Her skills, she was very...(pause)... she's good, she is a good listener basically, you know, like I would go to her with a problem about people attending and people who haven't got transport and have a difficulty or something has happened and she will listen and then she will sort it out. She will look at her chart and say 'Okay, maybe we can see this person in here.' ” (SW1 126 – 130)

Effective communication is a major component of a nurse's interpersonal skill repertoire, which is also essential for the successful practice of nursing.

Communication serves to create and maintain an essential connecting function for nurses and their environment.

Communicating well with health professionals is an important function of the nurse. Nurses have a pivotal role in keeping other health professionals informed about the patient so that there is an acceptable shared picture of the patient's situation, plan of care and care requirement, as the following quote illustrates.

“She is confident and assertive and gives direction to the team. ,, directed other people and took control especially when the mother was a nurse. To not waver in her decision making. to be very confident and quick thinking.” (N3 156 – 160).

Outstanding nurses were seen to be able to detect and respond to non verbal cues from the patient appropriately. These cues seemed to hold meaning for these nurses and elicit appropriate responses. One participant talked about some health professionals having the capacity to be able to interpret how people are feeling and what the impact was or might be of whatever it was that is happening to them at the time. He surmised that one needed to be *“perceptive of people's circumstances and I*

think there are those that are ... and there are those that just don't get it." (D1 38-42). The examples from the interviews below illustrate:

"She was always ...(pause)... you could tell, she would pick up on things. If the patient was uncomfortable about something you knew that she would notice that...., that would mean something to her. It wouldn't just be ignored, it would mean something to her. She would make sure she rectified it or make sure she spoke to the patient about it and discuss it with them, so they felt better about it, whatever it was that was upsetting them. If she couldn't put it right at least it was discussed." (N14 99 – 105)

[the nurse] *"...can see what is needed. Rather than the patient really crying out or like [the nurse] twigged that I can do something here so I'll do it. Rather than....Oh... hang on I'll get somebody to deal with this or I'll just pretend it's not happening because I'll be busy with the patient. So I guess having that perception"*(P6 121-127)

"Somehow this ability to look at you and know that you are in pain. Like this nurse ... would look at somebody and they were lying in bed and you are not too good and they would say 'Are you in pain [name of participant]?' "And you would say yes." "I thought so. Why haven't you told me?"(Pt9 526-529)

Outstanding Outlier

Most descriptions of outstanding nurses were consistent in their praise.

However, one nurse who was identified as being outstanding was described as such because she was considered to be clinically outstanding, someone with professional expertise. The nurse was described by the participant as, " ... extremely meticulous ... she is called upon to precept and teach ... good effective coordinator. If someone asks a question of her, without hesitation she knows it [the answer] without looking it up." (N2 202 – 215). However, her communication style was less than optimum. The participant went on to say, " She is rude, abrupt ... she doesn't share a lot with anyone, If you ask a question she will give just the barest, and just walk away, Just no social skills." (N2 222 – 227). The participant described the ward as being efficient and cold when the nurse was on duty. In this case, the participant valued and recognized the clinical expertise of the nurse but found the lack of social and communication skills detrimental.

The Good Nurse

The good nurse was described by participants as a nurse who performed well and was patient focused. The general view of the good nurse was someone who is competent clinically, knowledgeable, a good communicator, a nurse who works collaboratively and is caring. However, despite some similarities with descriptions of the outstanding nurse, the good nurse was described in slightly less enthusiastic terms. Descriptions were often accompanied by a qualifier or a comment indicating that there was some reservation about their work, or inconsistencies in performance. This meant that some nurses would have been considered outstanding except for the limitation. One participant said that good nurses [were]

“... good in their own little job, they are good in their own little niche. They do that job well. But they may not be willing sometimes to step outside their little cocoon of safety and help the other people ... but you could depend on them in an emergency because they can do their job well.” (N4 62-93)

The source of participants’ reservations included issues related to clinical competence, knowledge, communication, collaborative teamwork, caring and ability to cope. The themes for the good nurse are represented in Table 4.5 below.

Table 4.5

The good nurse themes

Reservations about Clinical Competence
Limitations in Communicating
Inconsistencies in Working Collaboratively
Caring Style
Coping

Theme One: Reservations about Clinical Competence

One limitation was in the area of assessment. An example of this was in wound care. One patient described her experience with the management of her wound, suggesting that nurses who did not perform minimal clinical skills such as wound assessment on a surgical patient were not considered competent (in her opinion) in the area of wound care. The participant during her length of stay noted that only one nurse had viewed her surgical wound.

“The doctor looked at it. This one nurse that helped me to the shower and she inspired confidence, she looked at it. So I would say they weren’t competent in that, considering that wounds are supposed to be part of their job. (Pt4 147-151)

A situation was described where a nurse was unable to assess a situation and anticipate patient behaviour. One participant described a good nurse he had worked with who had been head butted by a patient. He suggested that the nurse should have been able to anticipate that there was likely to be some kind of aggression perpetrated by the patient.

“The guy was a little bit agitated that morning and you were always taught to keep your eye on everyone. You know there are moments when you have to turn your back, but I think he did come from a fair bit of distance, four or five metres to do it. ... I think if he had been paying proper attention ... (pause) ... like saw him because he came at him from the front and he is a big guy himself and if he had been paying attention like he would have realised that it wasn’t quite right and maybe if he had said something like ‘What are you doing?’ and had a smile that might have deflected him and stopped him in his tracks. Because certain people once you capture them doing or whatever they are trying to do, they will stop.” (MHN2 407-418).

The lack of response to the patient’s behaviour was seen as being a significant deficiency as the participant believed that the outstanding nurse he had in mind would not have made that error of judgement. He said, “... and I think the difference would have been that the outstanding nurse would have seen it...” (MHN2 419-420). While the nurse may have been gathering data about the situation;

that is, the intentional directed movement across some distance from a known agitated patient, what was missing was recognition and understanding of the situation, causing a lack of action by the registered nurse to avoid or mitigate the problem behaviour.

Another participant described a situation where the nurse was unable to respond appropriately to a patient's behaviour on a ward. The ward was described as a 'special care unit'. The patient population was aged with a high proportion of patients who had dementia or a degree of cognitive impairment.

"If a nurse goes in and you can certainly pick out troubled nurses and how that has an impact and I can give you an example. There is one nurse for me who is outstanding in every way but she just hasn't got to know a lot of her family dynamics. She has got so much baggage and I was in a situation where a patient was being sexually aggressive, inappropriate and controlling and she was actually not able to handle the situation. Because within her own environment, the (pause) her role as a woman in the family, the way her husbands have treated her, the co-dependency crisis she is going through with her son who is quite violent and her inability to get out of that. ... it was fascinating watching this really outstanding nurse, when it came to patients overstepping boundaries she had no ability to draw a line and that really worked against the whole ward on this night shift. That was really dangerous because she was not seeing things early enough" (N7 64-82)

In the above situation, the participant describes the nurse as outstanding in "every way" except for her response in situations that arise where behaviour management is required in particular circumstances. This led the study participant to decide that the nurse could not be considered outstanding because of this difficulty in her performance and behaviour. His comments underline the importance of the context of care, and the extent to which nurses are able to respond across circumstances. In the mental health nursing context, competent care mandates appropriate responses to mentally unstable patients who make sexual advances toward them.

Inconsistencies in performance were also described. For example, some good nurses were not able to perform consistently at the level of a good nurse. One participant described a good nurse who she believed had some performance issues related to familiarity and management of the technology on the ward. The nurse was not able to reliably and consistently manage the technology, which then led to panic, suggesting poor coping skills.

“If she does have the skill, the nurse knowledge skill, she finds it hard to get the machine into order to accomplish whatever the problem is. She panics, or she doesn’t have quite ... just doesn’t have the same level of getting that happening, it might happen eventually I guess. ... you haven’t always got the confidence that she has the knowledge. She probably has, but sometimes you haven’t got the confidence that she has got the ... (pause) ... Sometimes it can click and go well and sometimes it mightn’t” (N8 540-549)

Good nurses were also limited in their ability to teach and educate patients. They were sometimes seen to be lacking in specific knowledge but had a more general knowledge.

“One nurse was the good one that actually introduced herself, and at some point during the time she was looking after me, she told me I should do pelvic floor exercises, but she didn’t actually tell me what they were.” (Pt4 105-109).

Theme Two: Limitations in Communicating

Participants also identified limitations with communication skills, indicating that good nurses might feel a little less ease about their communication style than outstanding nurses. Pondering the difference in communication was sometimes difficult for participants, but most believed it to be distinctive. It was suggested that certain good nurses were selective about who they would have a more open style of communication with.

“...he was often not standoffish but he wasn’t ... (pause) ... he was a little bit more abrupt so maybe that is why ... (pause) ..., he was never rude or argumentative but he was very clinical with the way he dealt with a lot of

patients and he would be a lot more open with some patients whereas he would be fairly clinical to others and I think and it's an assumption but maybe if you see that other patient you know if he seems very laughing and happy with one patient but being very clinical with another who is normally a very laughing joking person, then maybe that is where he is different to the outstanding nurse who was bubbly with them all, ...” (MHN2 444-452)

The following describes an Accident and Emergency nurse who was considered to lack some aspects of communication skills,

“... and she says what she thinks, but she knows her work, she knows what she is doing. Probably it wouldn't be the gentle way the other says to the doctors, 'come on we need to move along,' [it's] '...hey you guys, let's get on with it. They have been lying around too long, let's get on with it.' She is a good coordinator, she's a good triage nurse and she is perhaps not quite as softly spoken or gentle. She is gentle when it needs to be but she is a little bit rough, and rushed. But patients do respond to her and she sees the need when she needs to be gentle and understanding and always [a] caring advocate for patients.” (N10 210-222)

Some individuals described as good nurses had limitations in the area of maintaining personal and professional boundaries. For example, one nurse seemed to communicate with staff and patients inappropriately, divulging personal information

“The person who is very into therapy is doing so, [bringing the details of personal problems to the workplace] I am not quite sure if she realises that she is doing so. But some of her discussions have been inappropriate with us as nurses, I would like to think that she wouldn't have those discussions with patients, about her personal problems. I witnessed really, really angry outbursts from her, at doctors, at other nursing staff and several of the patients have refused (inaudible). There is (sic) a few problems at home. I have gathered that from what she has told me and yes, it is affecting her relationship with her colleagues and her patients. ... I think she is probably a good nurse” (MHN3 395-406)

Acknowledging others was seen as being an attribute of good nurses. A number of participants described the differences between nurses' approaches when having initial contact with others. One description of an outstanding nurse was someone who greets everyone and assumes that everyone wanted to talk to them. Another spoke about the outstanding nurse as one who would also have a quick chat

about general topics such as how their weekend went or talk about the patients. A good nurse would acknowledge others but would not necessarily initiate a conversation. *“... and the good nurse does not stop and talk, but she definitely acknowledges everyone. ... She certainly greets people”* (P1 603-607). One person described a good nurse as having a positive attitude and genuine interest in the patients. When the nurse came on duty she engaged with patients and staff by greeting them as she walked through the ward, *“Often on our ward she’s already talked to patients on the way up and spoken to staff members.”* (N7 409 – 411). Another described her good nurse as follows, *“She greets everyone in a friendly manner and then she would organise herself... .”* (N14 85-86)

In discussing a good nurse in theatre one of the probes I used was to ask how the good nurse would respond to a situation of tension and stress levels in theatre.

“ If you’re asking [about] this person that I am thinking about how she would respond, I think she would make it worse. The person I am thinking of would make it worse. ... Response is to fan the flames, rather than to pour water on them.” (N4 100-108)

Nurses who were thought to perform at a good level communicated the plan of care to the patient. One man explained that while the nurses he thought were good involved him in his plan of care, some did so more than others. Another participant said *“... came and said well let’s do this and let’s do that. Tell me what they were going to do and then we did it, whereas the other, the one that was more brisk wasn’t quite so communicative.”* (Pt 1 109-113)

Theme Three: Inconsistencies in Working Collaboratively

The teamwork aspect of the good nurses’ role was not consistent. One participant identified a particular nurse as being a good nurse because she did her job well but thought that she wasn’t particularly a good team member because of the

way she related to the rest of the team. *“She will run her anaesthetic side well. Probably almost outstanding but as a team member she is not good so it just makes her a good nurse.”* (N4 200-203)

Another nurse described a particular nurse as good, but someone who had poor communication skills, which led to the team being uninformed about patients’ appointments and investigations.

“I work with someone who is extremely ... (pause)... organisationally works very well. Things are organised on time. We have people coming in and out for treatments and that sort of (inaudible). Time[s] it well with their bloods and their appointments, those sort of things. But this person has poor communication skills and so no one else in the team knows what is going on. ... So he has got very good attributes in some areas and reasonably quite assertive as well, has good skills and has quite a lot of knowledge, but fails in communication” (N6 115 – 127)

It was evident that good nurses were seen to be clinically competent and patient focused, but they lacked team involvement. “...There was very much the ability to do the job and to manage the patients, but there wasn’t quite such a lot of involvement with other people.” (OT1 129 – 131)

Theme Four: Caring Style

Good nurses were described as being caring. Of the thirty two participants who spoke about good nurses, twenty two identified this characteristic. The nurses were often described as having a caring nature. When asked to explain how the nurses conveyed ‘caring’ most of the explanations revolved around words such as empathy, kindness, concern and listening. One nurse was described as,

“... the sort who patients will open up to in the middle of the night if she is on night duty. ... families can go to and ask what is going on and if she doesn’t know she will find out for them and what else.... Somebody who is very caring about the person’s welfare and caring about what happens to them after they leave her care as well and who will, you know, care, who shows that holistic care”. (SW3 253 - 258)

Having a gentle tone or gentleness in conversation and approach was important. One participant described this gentleness as *“not that jolly along which is sort of plastic like you are on a conveyor belt, sort of a gentle tone ”* (Pt4 132 – 134). Another patient commented that the nurse who looked after her on a number of occasions came and spoke ‘nicely’ and asked *“How are you feeling?”*, ... *“How is your family and how many kids have you got?”*(Pt8 195 - 203).

For one patient, caring was exhibited by nurses who informed him what was planned, even if he was being informed that she would be busy with other patients first before attending to him. For example, a particular nurse informed him,

“... I am putting you last on the list but I haven’t forgotten you, ... There was a degree of care and concern for you and it put your mind at rest so you weren’t lying there being agitated [thinking] when is somebody coming”
(Pt9 427 – 431)

Another informant described a good nurse as being “... very caring towards her patients, they were definitely her main priority” (N14 77 - 78)

Despite descriptions of caring, there were also exceptions, and criticisms were given. One participant went to some lengths to explain that although the nurse was experienced, her way of carrying out some of her duties left a poor impression. While some nurses were able to modify the way they carried out their nursing duties in the middle of the night the nurse described below showed little concern for the patients and their need for sleep.

“I think she was very competent, was good at her job, never had much of a smile but was very competent and ... it was as though she was in a hurry to get through it so she could sit down at the desk and write up her notes or

something....There was a lot of pain and stuff and you just get to sleep and she would be in with these lights on and I thought to myself that there must be a better way you could manage the night ward ... the others would sometimes if they had to come in and check one patient instead of turning on all the lights they would have these high powered torches, so they were showing concern. ” (Pt9 493-502)

Theme Five: Coping

Participants commented on the subtle difference between the outstanding nurses and good nurses and their responses to stressors. While the outstanding nurses never appeared stressed under any circumstances, including those that were personal, good nurses dealt with situations of stress slightly differently. One participant commented that *“at all times she [the outstanding nurse] could maintain her calmness ... and never did any personal upsets get to her”* in the case of the good nurse the description below was perceptibly different.

“... there was a time when she did have personal problems, that somebody made a comment ‘Oh, her heart is not quite in it in the way it was before’. She still did everything well and you knew she still cared ... but when her personal problems ... (pause) ... people had picked up that she didn’t have the same input ... (pause)... there was something holding her back.” (P4 264-270)

It may occur that the stress inducing situation was being placed in charge of the working area and this resulted in behaviours that demonstrated poor coping skills. One nurse in the operating theatre was seen as unable to cope when placed in charge and this had a detrimental effect on others.

“I have been told repeatedly she’s the best scrub nurse in theatre, but her glaring deficiency is that she can’t handle stress well, and if she is put in charge of a theatre, even before the list starts, she is a total fruitcake. It winds everybody up terribly. ... Like me in my position [new inexperienced staff member] I had to tell her to settle down the other day because it was a nightmare.” (N4 182 - 189)

While the good nurse remained an exceptional ‘scrub’ nurse in this instance, the good nurse was not able to cope with the added responsibility of being in charge.

Therefore her performance at her core role did not deteriorate until her role responsibilities increased.

Exceptions to Descriptions of the Good Nurse

Some participants commented on new graduates, and their perceptions were illuminating. One commented on a new graduate in the area where she was currently a staff member, initially describing her as outstanding and then later qualifying her statement.

“... This girl is going to be ... (pause) ... I think it wouldn't matter what career she chose in life, she's an outstanding person. ... with her outstanding nature is this affinity to absorb information and she's such a natural learner. It is exciting to watch this young woman just take on things and ummmm .. there is a real intellectual approach to the way she does things. As well as being very caring in her work. So I would maybe correct myself a little bit ... (pause) ... that she could almost be an outstanding young nurse.” (N7 622 – 632)

The Transitioning Nurse

Some nurses referred to in the study had characteristics associated with both outstanding and good nurses and, after some discussion, were identified as good nurses. One nurse was an expert in her previous area of specialisation but lacked specialist knowledge in the new area. However, she possessed many characteristics of outstanding nurses in more general areas of nursing. These were areas such as communication, standard of nursing care, showing respect and valuing the patient and her attention to detail as well as other characteristics, of which there were many.

“She was very caring towards her patients. They were definitely her main priority, and extra sensitive to their needs, was very thorough in her note taking and her reviewing of the patients notes and knowing what was going on with the patient and would be a good advocate for the patient ... She was keen to learn, she came in more as a junior level and really only spent a year with us, so didn't sort of get to the senior level, although she had been in a senior level in her previous experience which was orthopaedic nursing. So I knew she was well organised even with us because she had run the

orthopaedic ward. [She was] well organised and could judge others and so could allocate, she was good at knowing who could do what and whether this was a dangerous situation for this nurse in charge of these patients you know, so she was safe.” (N14 76 – 104)

The particular nurse was self aware about her own skill level and did not presume a higher level of knowledge, and she frequently asked questions of her colleagues when she did not know. “ ... *She was keen to increase her skill and her knowledge and never overestimated it ... she was always keen to learn and would always be asking questions.* ” (N14 92 – 95)

Her interpersonal skills were exemplary along with other aspects of her work,

“She greets everyone in a friendly manner and then she would organise herself. She would be on time, she would organise herself with the patients names and then we would go to handover. She was always happy to accept the patients that she was allocated she never complained. She always, as soon as she had settled her patients, she would always go through the notes thoroughly and make sure she understood their diagnosis and why they were on this medication and that medication. ” (N14 107 – 117)

A further observation by the participant was that the nurse always included the patient in discussions about care, “*Well when you would go and help her with pressure care or help her do something, she would always explain things to the patient.*” (N14 122 – 124)

Her attention to detail and diligence toward patient care seemed obvious to the participant. Although diligence may be seen to be mundane and the nature of the care provided also mundane, the nurse was consistent in attending to these details.

“Well I suppose you could see the patient was more comfortable, ... they had their mouth care done, they were propped up on pillows that were comfortable so physically they looked more comfortable and sometimes when you get cards from the patients they will mention specific nurses. Her name was mentioned,” (N14 141 – 145)

The participant went on to identify that what this nurse needed to be considered an outstanding nurse was to increase her knowledge and experience. Another nurse who was outside her specialty area was also described as having a considerable number of generic and professional competencies, despite lacking professional expertise in the current area of practice. The participant suggested that the nurse was a good generalist and would have performed well in a number of areas based on her good interpersonal relating skills.

“I guess a good generalist, possibly not as good as someone who worked in ICU all the time or in CCU all the time or in ED all the time but able to be brought from one location and put into that location and manage. And also know what she could manage. An awareness of what her ability was or wasn't Treated everyone with respect and that empathy thing regardless of whether it was a patient or a staff member or just ..., Just the ability to get on with everyone. Familiarity is not quite right but I suppose very much like the same skills that you need for a good manager and that you are aware of your staff and their family and you asked them questions and mean it. Not just walking by and asking how are you and not hearing the answer, but actually taking the time to hear the answer and say how's your son or how's your husband after that incident or whatever. Just that sort of whole person, well rounded person. (N15 118 – 152)

The above two cases have identified nurses who while not having the specific specialty expertise, were seen as having outstanding ‘people skills’.

The Satisfactory Nurse

The outstanding and good nurses can be seen as two discrete points on the same performance continuum, where outstanding nurses have exemplary qualities, and good nurses perform well in practice, with some limitation or inconsistency. However, analysis of the perceptions about satisfactory nurses revealed that their performance was less competent than nurses identified as outstanding and good nurses. One patient participant explained that being satisfactory was the basic requirement, but suggested that satisfactory nurses, while having the potential to

perform better, still had considerable improvements to make to develop to the level of a good nurse. Participants often described satisfactory nurses by what they didn't do or were not able to present. They performed at the perceived basic minimum standard which assured patient safety, but they often failed to provide a level of empathic care or have a higher level of knowledge or the critical thinking ability to anticipate patient needs and act on them. The satisfactory nurse was more likely to direct problems to other staff. S(he) was able to direct patient problems or issues to others and while able to recognize that a problem existed, could not problem solve.

The descriptions of satisfactory nurses indicated that the expectation of participants with regard to satisfactory nurses was not particularly high. They delivered a minimum standard of nursing care which was safe and did not endanger life. The satisfactory nurse was seen as someone who could administer medications and treatments in a timely manner. They also were seen as being capable of meeting a minimum standard in terms of documentation, legal requirements and bedside care. Some were seen to lack expertise in their particular area of work and so might still be in a learning role. For example, they,

“might be competent in terms of the physical tasks that they are doing. They might competently change the dressing, they might competently take the blood pressure. But they wouldn't be attuned to the non physical tasks I think with the patient.” (SW2 135 – 139).

Another participant said that satisfactory nurses were more likely to be operating at a level where they were fulfilling the duties of their nursing role, “ ... so it's more a case of just having done the tasks rather than anything more than that” (P5 58 – 63).

In this part of the analysis the themes identified were: Primarily Attending to Physical Care; Providing a Minimum Standard of Care; Selective Caring; Lack of Demonstrated Problem Solving Skill and Limited Interpersonal relationship Skills. The themes for the satisfactory nurse are represented in Table 4.6 below.

Table 4.6

The satisfactory nurse

Themes
Primarily Attending to Physical Care
Providing a Minimum Standard of Care
Selective Caring
Lack of Demonstrated Problem Solving Skills
Limited Interpersonal Relationship Skills

Theme One: Primarily Attending to Physical Care

Fourteen participants described satisfactory nurses using the following terms, *“just gets the job done”, “just doing the job”, “just doing the work” or “someone who does their job”*. Descriptions indicated that satisfactory nurses did their job but adhered to their own agenda. Nurses in an acute setting provided nursing care in an environment which was shared by a number of health care professionals and therefore was observable. A participant explained that how people spoke in team meetings about patients gave an indication as to what people think, care and feel. Whether nurses were observed to be with the patients and whether patients formed (professional) relationships with nurses while on the wards was also an indication of

the extent that nurses went beyond providing physical care only. It was noted by a number of health professionals that patients did talk about nurses to others.

The satisfactory nurses were often described in terms of what they didn't do. Participants described them as minimalist in their performance level, approach to patient care and engagement with patients and other health professionals. Some satisfactory nurses were found to be able to meet patient care requirements in relation to the physical care requirements, but they were unable to utilize problem solving and critical thinking skills when something occurred that was not part of the routine of the ward/unit, or when there was a patient event. Instead, they provided physical care according to the documented plan of care and treatments. The participants agreed that satisfactory nurses were able to do tasks such as the measurement and recording of routine observations but not able to problem solve.

"... come along and take someone's blood pressure. That is all she would do. Do the blood pressure and the obs and she would write them down and leave." (N12 167 – 169)

Another participant described the satisfactory nurse as someone who attended to the minimum standard of care but failed to provide any additional care.

".... it's doing the mechanical bits I guess. Err – being able to do injections, dressings, do observations that's doing the job. While you're doing the observations, actually you should be communicating with someone, providing the extra bits of support that goes with it". (D2 68 – 72)

Patient problems were able to be identified and then were passed on to others. One participant commented that, for him, satisfactory meant unsatisfactory.

"Satisfactory seems to be unsatisfactory to me ...(pause)... not quite up to the mark. That is what I think about the differences between ...(pause)... I can think of good nurses and excellent nurses and when I think satisfactory I think well they are people who aren't good nurses and aren't excellent nurses so that means unsatisfactory to me." (N6 149 – 161)

Another participant who had been a patient in hospital said,

“I think for me what makes the difference is all being equal, is if they all do the things they have to do, make sure you are comfortable, take your blood pressure, your temperature and give you your medications if they all do that, they are very satisfactory.” (Pt10 357 – 361)

Clearly, the above participant was describing a nurse who attends to physical care adequately but is not seen to be engaging any further in the care requirements of a patient. The satisfactory nurse was often described as very task orientated and able to manage routine care, but, in a busy environment, (s)he would struggle. This indicates poor coping skills in situations which weren't routine, which, as one participant suggested tended to happen in hospitals.

There were some instances where there was a limit to how much physical care would be undertaken. As one participant stated about a satisfactory nurse, “ ... *she would get more irritated if someone needs a lot doing for them, you know what I mean, she will come up in the office and she will complain about that patient, ...*”. (N14 187 – 190)

Theme Two: Providing a Minimum Standard of Care

In addition to being task orientated the participants perceived that satisfactory nurses saw their role boundary as limited to the minimum standard of care. The nurse would be able to administer medications on time, measure and record blood pressure, and give the standard type of treatments without anticipating or engaging in additional patient requirements. In general, the satisfactory nurse was described as someone who could, for example, make the patient comfortable in bed. This was in contrast to the outstanding nurse, who was able to make the patient comfortable in bed and attend to additional care requirements such as ensuring the call bell and bedside trolley were within reach. The nurse performing at a satisfactory level was able to prioritise care in terms of the tasks their workload dictated. However as one participant stated, their priorities were not always appropriate, with the nurse

believing that *“taking a blood pressure at 10 o’clock is more important than dealing with someone’s grief or stress.”* (N6 181 – 183). One participant identified that most care plans in general hospitals were a list of nursing actions to be completed according to the frequency or time the activity was to be accomplished. Because there wasn’t a section for such care requirements as counseling, this care requirement was never recorded. In the existing document-driven system, a nurse could then indicate that all care requirements were met as listed on the patient’s care plan. *“So it [grief counseling] doesn’t fit well on a care plan sheet so they are able to tick everything off at the end of the day but not do any of the extras.”* (N6 202 – 204) Their approach to care was also described in unenthusiastic terms,

“probably knows her working skills and knowledge but she is just there and just does it. It doesn’t really mean much to her, she is not really that interested ... and she is not really caring towards the patient, she doesn’t show care. She is there, she does work, you couldn’t say she is a bad nurse but she is there and she does her work and there is not a lot of enthusiasm. She never really gets to know the patient, never cares enough to show that patient that he or she is important ...” . (N8 49 – 59)

“Again just getting the job done ... the bare essentials but with no depth of engagement with the patient or team members, ...[not] for anyone else’s benefit but just for the purposes of getting the work done.” (D1 320 – 322)

“Does the job. Won’t go any extra, won’t do anything extra, everything is a big effort. Knowledge base is just adequate and doesn’t want to do anymore or doesn’t want to gain anymore knowledge.” (N13 130 -135)

The satisfactory nurse was not necessarily neglectful of the patients but was definitely someone who found it difficult to provide care beyond the essential.

Some participants (patients) identified that there were problems associated with undertaking some aspects of care on their own, as satisfactory nurses offered less assistance than nurses who performed at a higher level. This may have been because of the nurses’ poor patient assessment skills, but it was identified by the patients as a reluctance to provide assistance beyond a basic or minimum level.

“Yeah only once I got ... (pause) ... but I am not saying she is really bad she did ... (pause) ... she helped me. I can still remember, ah ... she helped me to go to the shower and everything but she just give me the stuff and she said ‘Just have a shower and then you finish. Just if you need my help just ring the bell otherwise you can come back’ or something like that yeah. But most of the nurses they came and helped me to have the shower. Yeah yeah, helped me to change my clothes and everything. Luckily those days [when the satisfactory nurse was on duty], my sister was with me, then she helped me.” (Pt8 247 – 254)

Another patient commented on the difference between an outstanding nurse and nurses who performed at a satisfactory level by describing their lack of attentiveness.

“...whenever she..., because I couldn’t stand up, I had to sit in the shower to start with. She always used to while she was making the bed, she would leave the bathroom door open so that I could speak to her and she would make the bed and clean that area and that she would just leave me with the hot water hose so I could just put it all over me for 10-15 minutes. Where some of the others wouldn’t do that. It was all we have to get you in and out. But she knew exactly what, and she had her eye on me the whole time, ‘and call out’ etcetera.” (Pt9 297 - 304)

In explaining the satisfactory nurses’ lackluster performance one participant suggested that some of the nurses may not have been appropriately employed within the health care facility.

“There were a couple of people [registered nurses] who I think that maybe were in the wrong ward. They did their job, they gave the medication, they took the blood pressures, they did all the stuff you have to do but they weren’t really into the recovery of the patient. ... there just to do their job.” (MHN2 279 - 291)

The satisfactory nurses undertook the more physical tasks and were able to follow a preset routine. Their level of performance suggested a lack of enthusiasm for the job and a limited repertoire of skills.

“Very much like I said, not cold but no ... (pause) ... without those humanistic qualities. An inability to speak to people like you are actually interested. Too fast, too wanting to move onto the next person, just getting through the day, again like I said in a robotic fashion, just doing what had to be done.” (N15 163 – 167)

While they were described as not doing any harm the satisfactory nurses seemed not to achieve patient improvements. The interaction and care activities were undertaken at a superficial level and in brief timeframes. They seemed to have little follow-up of patient care. One of the participants said,

“... she would come in and say ‘I am your nurse today’ and then wouldn’t even, some days you wouldn’t see her and then other days she would come in for only 5 minutes, and say ‘How are you going? OK? That’s nice, goodbye, see you’ ... Like she would say hello to you in the morning, give you your medications, check to see if you are going to the group today and then be on her way. ... and if you had a problem she would spend like a half a minute with you, ‘calm down breath, relax, here have a pill’.” (MHPt3 168 - 183)

In describing a particular satisfactory nurse one participant said *“does the job, won’t go any extra, won’t do anything extra, everything is a big effort... .”* (N13 130 - 133)

Another participant described a satisfactory colleague as showing a reluctance to attend to patients’ comfort needs. In explaining her performance at the start of the shift in the Emergency Department she said that the satisfactory nurse was,

“Fairly calm, checks out the situation, sees who is in, where she needs to ... (pause)..., who needs to go off, who needs patients taken over, pretty cruisy, we’ll get there, there is no rush to get anything done or get people comfortable.” (N10 259 – 262)

Outstanding nurses’ values were clearly visible to participants, as were the good nurses, albeit to a lesser degree. The values outstanding and good nurses displayed could be described as positive nursing caring values. However, for nurses who were performing at a satisfactory level, their professional values were more elusive. These nurses were described as being less empathic and compassionate.

“...you might find she is not so compassionate to the patients and maybe not as ... (pause)... wouldn’t show as much empathy with them if she is perhaps having a bit of a bad day herself. So there is not quite that level of empathy shown”. (N8 280-284)

Nurses performing at a satisfactory level were identified as not being able to perform beyond the immediate tasks and they did so in a timeframe that might suit them rather than anticipating any need of the patient. They were also described as being unable to multi task.

“There were a few satisfactory ones. They did their job but they didn’t know how to do anything else and they were often the ones who would make people wait. They couldn’t do more than one thing at a time.” (OT1 68 - 70)

“ ... normally when I ask something no one refuse to give me even sometimes it is a bit later a bit late to come to me but still they never refuse to. Or if I ask [for] ice, or a drink or anything or if I want any covers to go to the shower, sometimes takes a time, but they never refuse [say], ‘No I can’t do that’ or they never refuse to do that, yeah, everybody did their job.” (Pt8 102 – 107)

One participant commented on the fact that once the more technical aspects of her care were completed that there was very little nursing care undertaken beyond tasks.

There was no education or information given on an informal basis.

“... once the drip and the catheter was out I suppose there wasn’t any other technical skills they had to demonstrate. Utilising the time when they were taking my temperature I think maybe they could have chatted to me a bit about health issues or asked me if I had any questions. I don’t remember anyone actually asking me if I had any questions. So I suppose they drifted in and out you know and general chat. I didn’t get the feeling that there was any great skill required to be a nurse but that was maybe because I didn’t need them or I wasn’t sick or something.” (Pt4 250 – 260)

Sometimes there were discrepancies noted between the way the patient’s condition was and the entries in the case notes. There may have been omissions of patient care which were either not explained or glossed over. As one participant said in describing a satisfactory nurse at her workplace,

“ She comes on and she is quite cheery, gets her work done fairly well. Sometimes her reports are written better than what the work is done. You might read the report and think goodness and sometimes it is not quite equal to the, ...(pause) ...some people can write really good reports but the patients sometimes aren’t as quite well looked after. All the things aren’t done.

[nevertheless] *things would get accomplished fairly well but that is it.*”
(N8 266 – 272)

Satisfactory nurses were noted as not volunteering for extra duties. They often didn't participate and therefore were invisible in the sense that they failed to make a mark or be a presence on the ward. One participant commented,

“... or looking into protocols which go with the job as well, which is the take home work because you don't have time at work and those sort of things. Or noncommittal in discussion whether it be debriefing or meetings, or probably in meetings or doesn't always go to the meetings or “they can go and I will stay here” something like that. Not contributing to that team and that area.
(N10 291 – 297)

One person commented that she had experiences where she had difficulty finding the nurse who was responsible for the care of a group of patients. “... and you find the name on the board.....they're not around, and maybe they're on tea break, ... you walk in five minutes later and they're somewhere else, and no one knows where they are...” (P2 306 – 310)

Some satisfactory nurses were not seen to be very effective nor were they seen to be interested in patient care. As one participant summarized,

“She wasn't a bad nurse. She just wasn't into the patients and wasn't into the job either. I think she stayed 12 months and once she had been there for a while she realised it wasn't for her and it wasn't what she wanted to do.”
(MHN2 626 629).

Theme Three: Selective Caring

A number of participants explained that some of this group of nurses seemed to be selective about which patient they would be willing to be allocated because of their preferences. The preferred patients were often those who required less complex care. The patient who might not be popular with the satisfactory nurse was the patient who required more than physical care, such as emotional care, or the patient

who required complex clinical skills from the nurse, such as multi trauma care. For example,

“See the...(pause)...., oh how can I put it. I suppose the apprehension, would prefer to go and look after the clients that are perhaps easier to look after and perhaps stay away from the ...(pause)... umm and observe all the others, take over those roles, I suppose, and not interfere, ... ”.(N10 263-269)

The next participant explained how the satisfactory nurse would interact with patients for whom she was more willing to provide care, but not so willing with other patients.

“There is one nurse I can think who is on the ball. She knows what is going on. She is safe, she has a good knowledge basis and she ...(pause)... the patients, probably with the weller [more well] patients she is quite good. Because she is good with her verbal skills and having some fun with them you know. Like you get a young man in with angina and he is 45, and she can keep them happy and interested but she hasn't got that real caring for somebody who is not as interesting to talk to. But her knowledge base is very good for that person who is old and very sick so she has got some things that are really good to give and other things that are not so.” (N14 177 – 186)

I asked the participant if she had an opinion on what aspects of care the patient would not receive.

“Probably miss out on the personal touch, the physical comforts and the emotional support. This nurse can also tend to be a little be curt. ... Well if a patient was acutely sick, her observation skills were good, her knowledge basis was good and ... with the younger patient and the not so sick patients, she would have good interaction with them. Like she would have a joke, she would be doing their observations, and they really responded to her quite well you know, because they would be talking about things. There would be laughing and joking and I could tell they quite enjoyed having her as their nurse because she did really relate to them very well. The younger more able, maybe even especially men. Whereas the old like CVA who needed lots of care and who was really a medical patient rather than a coronary care patient, maybe they had had a small heart attack or something like that weren't all that unwell, maybe that patient would be treated more like an object and not ...(pause).... But then she was good with the acute stuff as well, I suppose it is just what appealed to her really. But not everything appealed to her” (N14 327 – 341)

Although the above extract from the interview is lengthy, it illustrates how the nurse is selective in her level of engagement with patients and how the provision of care alters according to the patient allocation. Where staff shortages occur, or the skill mix of staff is not optimum a senior nurse may be compelled to allocate the satisfactory nurse who performs poorly with the complex patient, which limits the extent to which the patient's care is comprehensive. The same participant went on to say,

"...the satisfactory nurse like she is only willing to give her best with the patients that she likes to nurse. Whereas the patient that she doesn't like to nurse she stops short definitely. I think that is a lack of generosity of spirit because with her I think that she can see it." (N14 491-494)

This poses a management challenge for patient allocation. The nurse who is selective cannot be allocated the patient who requires more advanced nursing skills as the coordinator would not be assured that these skills will be provided.

The selectivity issue was also evident in a visible lack of enthusiasm. One satisfactory nurse was described as preferring not to participate when more mundane tasks were required to be completed, only becoming energized when there was an emergency or when acute care skills were required.

"One person I am thinking of right now is an excellent nurse in that whenever the need is called for she works. But when there is nothing really big happening she tends to sit back and let everyone else do the mundane kind of work ... has the knowledge and whenever there is an emergency is in there and can do it. ... loves that kind of thing but has been there for years and is still sitting there 15 years later from when I first knew her doing exactly the same thing. Doing as little as possible of the mundane things" (N1 71-84).

Another participant explained her attitude towards working with a nurse who was just satisfactory.

“As long as somebody is really sick she will be by your side helping you if it is your patient. You would want her there because she has the knowledge basis, and she is not work shy, when the action is on. She quite likes the acute and the action but as far as the dreary goes she is not so keen on that ... , she likes the high powered, interesting... .” (N14 267 – 272)

Some satisfactory nurses were seen as procrastinating or using avoidant or delaying tactics. The satisfactory nurses were seen to be engaged in at face value valid and explainable activities but the end result was the patients did not receive aspects of care.

“... they maybe sit in the nurses’ station and don’t go out and talk to patients. Or when they do talk to patients it might be a token effort of 1 or 2 minutes. When they’ve got time to spend 15 minutes with the patient they would be often doing whatever it was they were doing. ... they would find things like take 20 minutes to go get a medication or take 20 minutes sitting in a room and having a coffee, because you have a lot of time where you don’t really have to be doing anything. Or maybe reading a book on a condition which is good to do, because you do need to understand a patient but I think after you have got that understanding you need to go and develop your own perception of the patient by talking to them armed with the knowledge from their history and where they are now. To be quite honest I don’t know what it is they do. They will be in a ward and you just never ever really saw them talking for long times with the patients, maybe they did when I didn’t see them. But if they did maybe only to select patients, maybe some of the more likeable patients not the more challenging ones that would take a lot of time to talk to and a lot of patience and understanding.” (MHN2 597 – 612)

Another participant expressed concerns about satisfactory nurses having a lack of generosity of spirit. This was described, as someone who engages with the patient but is guarded or who has their own agenda rather than the patient’s agenda in mind,

“... that if something is asked to be done ... might hold off until the change of shift until it gets done so the next shift does it. ... might ask someone else to do it, not in a true delegation sense but what don't I have to do rather than what can I do.” (D1 185 – 190)

Some satisfactory nurses practised outside the agreed plan of care. The example below illustrates how it may well become confusing for the patient when different modalities of care were implemented by different staff members,

... she's a mental health nurse, and I think I am not sure, she may have done a counselling course so she tends to think therapy is a very good thing you know, but everybody has to be in on the act. It is no good me trying to get you to participate in a particular therapy if the rest of the team don't think that it is a good idea. But if you are going to be difficult with the rest of the team and have arguments with them and then you are going to pressure your patients as well, that is bad.” (MHN3 225-233)

Theme Four: Lack of Demonstrated Problem Solving Skills

A further limitation among satisfactory nurses was their lack of problem solving skills. When problems arose the satisfactory nurse passed on the problem to either the oncoming nursing staff or to the shift coordinator. The problem then became the responsibility of someone else.

“I can think of someone ... and I can think of their method of dealing with anyone who has got issues and that is to basically pass it on to someone along the line. So they are good enough to report that this person has got the problem but they are unable to deal with it.” (N6 157 - 162).

Some participants identified that satisfactory nurses may be nurses new to the area and therefore would lack skills in problem solving because of lack of experience;

“Well in a way I suppose ... that's how I would see myself. As an inexperienced nurse, satisfactory in that I can do the job as long as nothing goes uproariously wrong.” (N4 205 – 208).

Satisfactory nurses were also seen to take longer to identify and act on patient problems. One participant commented,

“ well she does the basic care and will measure urine outputs and stuff like that but doesn’t always recognise the significance of her findings. So she won’t maybe equate that the urine output has been down for the last four hours or that the blood pressure is dropping or the pulse is dropping. It would probably register eventually but it would take her longer to recognise that maybe there are deviations from the norm.” (N12 477 – 484)

Some satisfactory nurses were perceived to lack knowledge which led them to make incorrect decisions about patient care. One participant described a situation where in attempting to solve a patient problem the nurse’s poor knowledge level led her to make a poor decision.

“... there was a situation where a SATS reading [machine reading] didn’t work, and rather than check to make sure that the probe was working, the oxygen got put up, right up to ten litres, and that just, you know, to me, that was like, “Oh my gosh, you don’t understand the dangers of doing that”. So that was quite an obvious “don’t have” that academic knowledge there to realise the dangers of what you’ve just done.” (P5 217 – 224)

When a nurse did not demonstrate a good knowledge base then staff who would normally seek out nurses for patient information would approach the medical staff for clinically specific information rather than the satisfactory nurse whose knowledge base was seen to be poor. New allied health staff often approached the more knowledgeable nursing staff for information about the patient’s clinical condition to help make decisions about undertaking patient treatments. As one physiotherapist explained,

“So I’m reliant on the nurse’s knowledge in that respect, yeah, to be able to say yes or no, we can do these things. when I first qualified ...[pause] ... orthopaedics is a classic sort of area that newly qualified physios, if you haven’t got a senior physio working with you, rely on the nurse’s knowledge. Because that’s a very clinical area in that, you know, we do this on the ward, and because it’s so, you know, everyone does the same thing with patients, that I would say a lot of new, newly qualified physios, ... rely on nurses.” (P5 247 – 258)

Satisfactory nurses were seen to lack initiative when confronted with patient care issues. So in the example given earlier the satisfactory nurse was not able to

deal with the patient issues on her own initiative but waited until directed by another nurse.

“A satisfactory nurse, ... I think one that is a little bit apprehensive, ... for example multi trauma, not just quite sure what to do next. Not so much what to do next, but waiting for instruction. ... have got the knowledge, they can deal with the relatives, but they just seem to be ... (pause) ... always not taking initiative”. (N10 246 - 255)

Some satisfactory nurses were perceived to have poor coping skills when there was increased pressure and stress and therefore their problem solving abilities were not evident particularly in relation to continuing to coordinate the ward. This pressure arose for one nurse when there were events outside the ward's usual routine. So the nurse was unable to deal effectively with the issues as they arose during the shift. One participant described a situation in which the nurse became stressed. The nurse placed in this situation would not be able to perform her usual role and would need to be supported to complete her responsibilities for the shift.

“I don't think she has got the personality to be a Level Two, this particular girl I am thinking of. I think it has almost been forced onto her, and she just doesn't cope. It is not once, it's most times. ... yet she's probably a very good nurse. It is just that emotional things, she panics. She probably has got the skills to be the good nurse but she panics and just loses the plot a bit, so she can't really do her level two job as well. ... they have to run the ward. But if any outpatients come in they often have to assess them. She panics as soon as there's more than one or two come in. Or if she has to admit someone or do something because we have got a full patient load and you find you end up carrying her as well as doing your own work because she is just not coping.” (N8 231 – 257)

Theme Five: Limited Interpersonal Relationship Skills

Satisfactory nurses exhibited a lack of interpersonal skills. They were not always professional in the way they engaged with other professionals and patients and their relatives. For some, but not all, their communication limitation was evident in a number of different ways. For example, as noted previously, approachability was considered to be important. Junior staff would find it intimidating to approach

the satisfactory nurse regarding patient problems, as indicated in the comment below.

“ ... this satisfactory nurse could be quite critical of other nurses and she would be fairly(pause) ... I would say ...(pause) ..., other nurses would be quite scared of her. They wouldn't feel comfortable in approaching her with a problem. But if they did want to learn something and they approached her appropriately then she would be the one to learn from.” (N14 205 – 210)

I asked the participant what would be thought of as an appropriate time.

“At a time that was convenient and probably depending if this girl liked the person who was approaching her that might make a difference. She was very much ...(pause)... she either liked you or she didn't like you. And if she didn't like you, well then you were, you weren't good company, or you weren't this or that. She wouldn't be as interested, she wouldn't be as interested in teaching you or she wouldn't be as interested in helping you with your patients or ... and the patients would probably pick up on that sort of abruptness sometimes.” (N14 212 – 219)

Some allied health professionals explained that with satisfactory nurses there wasn't the willingness to assist. Approaching a satisfactory nurse for assistance was treated more like an imposition by the nurse.

“If something had to be done, she was efficient in what she did. There was a certain amount of days when you needed help with someone... ‘Could I have help with someone?’ You could sense a little bit of ‘(sigh) okay’ type of thing. She'd go and do it, she wouldn't say ‘Oh no I can't’, but there wasn't the willingness. You'd feel as though you were imposing on her or you were interrupting her from something.” (P4 280 – 287)

They were not seen to model team participation behaviours well. One senior nurse engaged in behaviours that suggested that he shouldn't be approached.

“The person I am thinking of is a senior nurse, been there 10 years plus but the junior nurses will tend to go to someone else ... for advice because they get fobbed off. So they are not a team player ... there will be complaints along the way, that is what happens and pretty soon people get the message [to seek assistance elsewhere].” (N6 207 – 220)

The lack of approachability was echoed by one of the allied health professionals “ ... it’s, you almost get the impression they may know, but they just can’t be bothered at that time to explain it to you because maybe they’re too busy. Or yeah, it’s, “you get that?” (P5 382 – 384). Another communication limitation was described as a lack of discretion; for example, in complaining about a particular patient within hearing range of other patients,

“... complaining about some patients. Really OK, that is probably fine, some patients are way difficult. But maybe in the earshot of everyone else is what is the downfall rather than just saying to the other nurse, lack of discretion probably. Really no patient or someone visiting doesn’t want to hear that especially [when] they are talking about someone they are about to visit.” (Pt6 187 -192)

Satisfactory nurses sometimes voiced concerns which were more appropriate not being said in the presence of the patients and also the staff.

“... she will come up in the office and she will complain about that patient, ... she wouldn’t be as interested, she wouldn’t be as interested in teaching you or she wouldn’t be as interested in helping you with your patients or...(pause) and the patients would probably pick up on that sort of abruptness sometimes.” (N14 188 190)

In addition, a number of participants expressed some concern about satisfactory nurses commenting about their lack of confidence in the presence of patients, “... voice the opinion it is a while since she has looked after these sort of patients ...” (N8 625 – 629).

“I mean as regard to a lady that was having a port changed in her arm. The nurse was obviously not confident about what she was doing, said she wasn’t confident about what she was doing and it looked terrible. ... the poor patient, even if you don’t feel confident about what you’re doing ... You don’t have to tell the patient that.” (P6 40 - 46)

A number of participants expressed reservations about satisfactory nurses' communication style, with their communication style seen to affect inter-professional relationships.

"I suppose she spends a lot of time talking. She does talk to the patients, which is good, that is important, but you don't always get the full information when it comes to a handover. But the patients' care has been done and I suppose you have to go and get to know your patient too but I find she talks a lot. ... It could be the caring aspect of well how did they go or something like that, but it doesn't always come across as that."(N10 369 – 381)

One participant described how one particular nurse's way of communicating had a detrimental effect on her,

"... a girl [registered nurse] who had a real chip on her shoulder with life in general and she always voiced those. But that wasn't her work it was more the staff relationship that it affected. So it wasn't her work ... I can remember one that just had a real chip on her shoulder about several things and she was always voicing them and that sort of, can really get you down after awhile." (N8 669 – 675)

Another person described the communication style as being rather abrupt, particularly when that particular nurse was communicating with relatives,

"This nurse can also tend to be a little ... curt with the relatives and not sort of, the relatives might sort of get put off, they might think that nurse is rude the way she is doing that. Maybe her attention to the patient's privacy was not as meticulous." (N14 260 - 264)

Clarity of communication was sometimes not evident.

"... there is the approach that they make to the patient that is totally different again and it is very much, oh umm ... can't talk on the same level as the patient, really talking down ... It is as though they just can't function any other way. ... and it doesn't work... ." (MHN3 242 – 248)

Satisfactory nurses did not usually act as the shift coordinator, however, when it was necessary to take on the coordinator role they exhibited a less than optimal management style when managing the ward or unit. This is illustrated by one satisfactory nurse who had a forceful style when managing people and who made

decisions which were in keeping with hospital policy. However, she was perceived to enforce them in an authoritarian style. In talking about her interpersonal and management skills the participant said,

“You could tell some things had gone badly, mainly from conversation and how friendly she would be, to the patients also not just us. ... she was quite pushy with the doctors and nurse management which was sometimes inappropriately pushy. ... As soon as there was a patient in the emergency department she would want to know what was wrong with the patient. Then she would want to speak to our resident. She would want him to tell her what was wrong. Then she would decide, ... you don’t need to admit that patient, atrial fibrillation is not a reason for admission to CCU. So then we have fairly junior doctors, they are only resident doctors in their second year so she was fairly.(pause)... she would push them around a bit, ... and nursing management, she was fairly forceful with them. ... she would just about shuffle patients around the ward herself, to get rid of somebody from the unit that she didn’t really want there maybe or didn’t think was appropriate we had them ...”. (N 14 233 - 249)

The same participant went on to describe how a satisfactory nurse’s conversation may be inappropriate when undertaking care activities with a patient. The nurse had a very functional approach toward the patient, treating the patient as an inanimate object,

“She tends to talk about things outside of work when you are in with the patient doing something. Like she would be talking to me about what had happened to her that day when we would be doing pressure care. Whereas I tend to think that needs to be left till later and while you are in with the patient you are only talking about what’s relevant to what you are doing? there wasn’t sort of you know, acknowledgement of him as a person so that we could talk appropriately about something that was to do with him, you know.” (N14 313 – 324)

Another nurse lacked personal discipline and this was identified as lacking respect for the team. The participant said,

“I think it [discipline] is just a general term I am using in terms of arriving at work on time, having things organised in a way ...(pause)...At the moment I work in a clinic which is very orderly. ... the people who are disciplined always do things a certain way. When you’ve finished with this you put it

there, ... you clean up your rubbish as you go. You do all those sorts of things. I think if people aren't disciplined then they will leave rubbish there, never find a pen, you know all these sort of things, I am thinking of a person in particular and there are a hundred little things that are annoying about what they do. But none of them important on their own but if you look at the whole picture the only thing I can come to is that they are undisciplined. ... an unreliability goes with that. Whereas people that are disciplined you always know that if they've done something with the patient, they will have put the forms there, they will have tidied it up, followed it up with another appointment. They would have done all these things." (N6 226 – 245)

Summary

In this chapter the participant demographic characteristics were reported. The attributes of outstanding, good and satisfactory nurses were outlined according to the perceptions of the participants in this study, within a number of major themes. For outstanding nurses five major themes were identified. These were: Sustaining a High level of Performance; Modelling Exemplary Professional Behaviours; Balancing the Personal and the Professional; Managing Self and Others and Forming Personal and Therapeutic Relationships. The five major themes identified for good nurses were: Reservations About Clinical Competence, Limitations in Communicating, Inconsistencies in Working Collaboratively, Caring Style and Coping. There were five major themes identified with regard to satisfactory nurses. These were: Primarily Attending to Physical Care; Providing a Minimum Standard of Care; Selective Caring; Lack of Demonstrated Problem Solving Skills; Limited Interpersonal Relationship Skills. The major themes for outstanding nurses also included sub themes which further explained the attributes of outstanding nurses.

The findings shed new light on how nurses are perceived by their patients and their professional colleagues. They challenge the notion of consistency in nursing practice, indicating wide variation in the way nurses combine personal and professional characteristics in the context of providing care. A number of important issues arose from the study findings and these will be discussed in the next chapter.

CHAPTER FIVE: DISCUSSION

THE SEARCH FOR EXCELLENCE

Introduction

This study set out to investigate the characteristics of satisfactory, good and outstanding nurses. The participants in the study all had experiences of interacting with registered nurses in hospital settings. It was not surprising that a majority of the study's participants were female, as females dominate in the health care professions. The participants expressed a keen interest in the topic area and a willingness to participate.

The overall aim of this study was to describe the characteristics of outstanding, good and satisfactory registered nurses practising in clinical settings. This was supported by three research questions. Firstly, how do patients, nurses and medical and allied health personnel describe satisfactory, good and outstanding nurses? The second research question was, What is the shared understanding of what constitutes a satisfactory nurse, a good nurse and an outstanding nurse? The final question was intended to identify the differences in perceptions about the satisfactory, good and outstanding nurse. The methods used to gather data in this study yielded sufficient information to provide comprehensive interpretations of participant perspectives on these questions. Most shared common views on the differences between the good, satisfactory and outstanding nurse, although some differences did emerge, which reflected participants' experiences or exposure to nursing care. Some characteristics of each type of nurse were congruent with what

has been previously published in the nursing literature, while some findings were unique to this study.

Participants' Perspectives: Satisfactory, Good and Outstanding Nurses

As indicated in Table 4.4 there were five major themes describing outstanding nurses. These included Sustaining a High Level of Performance; Modelling Exemplary Professional Behaviours; Balancing the Personal and Professional; Managing Self and Others; Forming Personal and Therapeutic Relationships.

The findings present unmistakable evidence that some nurses in clinical practice are outstanding, in particular at the ward/unit level within acute care general and mental health facilities. The outstanding nurses were not only considered high performing nurses, but they were able to facilitate and ensure a high level of performance from other staff members. Their professional behaviours were exemplary. They were also seen as having the ability to balance their personal and professional life so that problems or stressors in their personal life did not 'leak' across into their professional life. The outstanding nurses were not only good leaders, they were good managers, managing themselves and others. Prolific comments were forthcoming about how they were able to maintain relationships with others well, and they did so with effective communication strategies.

Outstanding nurses were seen to be more than just good nurses, an observation that was also made by Kendall (1999) in a study identifying outstanding oncology nurses.

The outstanding nurses were seen to be exemplary in delivering high quality nursing care. They also generated personal warmth and formed conducive relationships with other health professionals. This level of interaction enabled

optimum care for the patients. These nurses were a highly positive influence in their workplace and had many characteristics, such as approachability, enthusiasm and a generosity of spirit which attracted admiration and inspired others. It seemed as though the whole self was on display and that the outstanding nurse did not have a clumsiness of being. They were available to both the patients and staff. Being available and accessible to patients is an important aspect of nurse caring and the delivery of quality nursing care. Their availability is an aspect of nurse caring. Fingeld-Connett (2008) indicates that caring is a context-specific interpersonal process that is characterized by expert nursing practice, interpersonal sensitivity and intimate relationships. The outstanding nurses in this study were identified as displaying all these aspects of nurse caring well.

Sustaining a High Level of Performance

The level of knowledge of outstanding nurses was remarkable, and this was seen to extend beyond clinical competence. Outstanding nurses were sought out by nurses and other health professionals because of their knowledge in the clinical area. This was well supported by the comments provided by the participants who either sought the advice of outstanding nurses or observed that others did so. The patients also commented that the outstanding nurse was someone who had superior knowledge and that it was highly likely that the nurse had undertaken further studies or was in the process of doing so. The outstanding nurses were also the group of nurses who were involved in patient and family teaching. Participants did not comment about good and satisfactory nurses undertaking any patient and family teaching. Outstanding nurses were the group who most resembled Benner's (1984) description of the expert nurse. Although this research did not attempt to study the nature of expertise, it is clear that there were performance characteristics about

outstanding nurses which led a number of participants to perceive this group to be extremely knowledgeable about their specific practice area. This knowledge supported a number of other practitioners in the performance of their roles and therefore it could be said that through this willingness to share their knowledge the outstanding nurses enabled others. Sharing knowledge also indicated their willingness to work with other patient care team members, suggesting that they would be productive in a team environment. It is important to acknowledge that these nurses were highly respected for their specialised knowledge in a particular field of nursing and this knowledge was valued by all groups of participants in this study.

Both patients and health professionals, particularly the nurses, spoke about safety and how the outstanding nurses created a safe working environment which they highly valued. This focus on safety and the ability of the outstanding nurse to create a safe environment through communication and people management skills was an original and unique finding of the study. There have been a number of studies undertaken in nursing to investigate the incidence and level of threat to patient and staff safety through disruptive and violent behaviour in acute hospital settings (Coe & Gould, 2008; Crilly, Chaboyer & Creedy, 2004; Hutton & Gates, 2008; O'Connell, Young, Brooks, Hutchings & Lofthouse, 2000; Rosenstein & O'Daniel, 2008). Disruptive behaviour in healthcare has been identified as a threat to the quality of patient care, nurse retention, and maintenance of a culture of safety. Previous studies have investigated what strategies and interventions may be put into place to reduce aggressive behaviours (Anderson, FitzGerald & Luck, 2010; Thomas, 2010); the level of stress experienced by staff when difficult behaviours arise in patients and staff, and perceptions of violence by staff (Roche, Diers,

Duffield & Catling-Paul, 2010; Walrath, Dang, Nyberg, 2010). However, studies have not shown previously that outstanding nurses contribute to the containment of disruptive behaviour from patients and staff and its effect on improving individual staff performance and morale. In this study, staff and patients valued the sense of safety and security that this containment of behaviour gave them. Feeling safe was an important aspect of the work culture generated by outstanding nurses. This was an interesting finding and it underscores how vulnerable staff and patients felt when incivility, disruptive behaviour and aggression were evident to them in the hospital setting. Staff and patient participants reported that their experiences of being upset, threatened or vulnerable were diminished because of the way outstanding nurses managed these situations. Patients also feel safe and secure when they are well cared for by nurses who are competent.

It is interesting to note that nurses performing at a good or satisfactory level were not identified as being particularly skilled at managing disruptive behaviour. On the contrary, there were instances described where good nurses did not respond appropriately to patients who were behaving in an aggressive and inappropriate manner. Satisfactory nurses were not described as being involved in situations requiring behaviour management, and this may have been because they were not recognised as being capable of managing patients and staff with challenging behaviours, or having the appropriate communication skills for this role.

Outstanding nurses were also identified as the group who embedded client-centred care in their practice and role modelled professional values and behaviours. Patients identified this as very important and outstanding nurses demonstrated an approach which indicated that the patient was their focus of concern and attention. Patient-centred care has become synonymous with high-quality care, and is a

standard of practice that demonstrates a respect for the patient (Binnie & Tichen, 1999; Shaller, 2007). Patient centred care is established through good communication and including the patient in decision making. The outstanding nurses demonstrated patient centred care by not being task orientated nor mechanistic, providing care where respect was shown toward the patient through their inclusion in decision making. This need to show respect is also addressed by McCormack (2003 p 181) who writes that patient centred care involves ‘... respect for persons and reflects commitment to having a deep understanding of the other person ...’.

Acknowledging the right of patients to be partners in their care through active participation in joint decision making by the patient and nurse may lead to better patient outcomes and has been shown to increase satisfaction with care (Anderson & Mangino, 2006; Robinson et al., 2008; Sidani, Epstein & Miranda, 2006). A patient’s sense of control, and functional and clinical outcomes can increase when patients are involved in treatment decision making (Sidani et al., 2006). Patient satisfaction was also reinforced in a recent study of nursing bedside handovers, where patients indicated that they appreciated being acknowledged as partners in their care by having input into the information handed over (McMurray et al., 2010).

Patient centred care was not always evident with nurses performing at a good or satisfactory level. The nurses performing at a satisfactory level were very task orientated in their approach to patient care and therefore it is not surprising that participants perceived them as lacking a patient centred approach to their care.

Modelling Exemplary Professional Behaviours

Participants perceived that outstanding nurses were highly professional in the way they went about their work. Their compassion was notable. Their respect for others and perseverance were indicative of the way they lived out their beliefs and

values in their patient care. Similar findings were identified by Stanley (2006, 2009) in his studies investigating clinical nurse leaders where clinical leaders were found to have their values and beliefs on show and evident. Although the outstanding nurses were not described as ‘caring’, that is using the word ‘caring’ as a descriptor of their emotion –based or action based nursing qualities, there is some indication that caring was embedded in their practice, particularly in practising from a strong foundation of knowledge, in a way that showed compassion and warmth. They showed compassion and concern for others, and showed respect and a generosity toward others. They seemed to find the right balance between intimacy and respectfulness. Kendall (1999) found in her study of outstanding oncology nurses that participant caring descriptors were predominantly focused on the ‘care about’ component of caring which was considered to be affective or emotion - based. This study has found that the outstanding nurses focused on both affective caring and on action based caring demonstrating overt caring behaviours.

Balancing the Personal and Professional

An interesting finding was that the outstanding nurses were able to compartmentalise their home and work life. Issues or stress in their personal lives did not impact on their performance at work, nor did it dominate in the workplace. In other words, whatever may not be going well in their personal lives did not ‘leak’ across the boundaries into their working life and create difficulties. The problem of personal difficulties ‘spilling over’ into the workplace has been identified in the psychology literature (Michel, Mitchelson, Pichler & Cullen, 2009; Palladino, 2006; Wierda-Boer, Gerris & Vermulst, 2009). However, in this study these high performing nurses were able to demonstrate quite clearly that if there were problems in their personal lives this did not impact adversely on patient care,

and good interpersonal relationships continued to be maintained between patients and health professionals. However, there were noticeable differences with good and satisfactory nurses. When there were problems in the personal life of good nurses participants indicated that there was a perceptible change in the level of engagement. The satisfactory nurses were reported as discussing aspects of their personal life while attending to patient care. So there was no restraint by some nurses in the presence of staff or patients.

The outstanding nurses' personal characteristics were also visible, and this included being happy at work, being enthusiastic and having energy. An important quality in outstanding nurses identified in this study was that they were described as happy in the workplace. Having a sense of humour was identified by participants as being important in nurse patient relationships, a useful strategy to lighten up some situations and as a coping mechanism to face stressful circumstances. Humour has previously been identified as being important in nursing as has been an optimistic attitude (Perry, 2009). Other researchers have also identified humour as being a useful nursing strategy to enhance nurse-patient relationships and improve the quality of communication (Astedt-Kurki, Isola, Tammentie & Kervinen, 2001; Mallett & A'Hern, 1996; McColl, Thomas & Bond, 1996; Sumners, 1990), thereby improving patients' well-being (Astedt-Kurki & Liukkonen, 1994). What was also valued was that the outstanding nurse maintained a happy demeanour consistently in the workplace. The outstanding nurse's demeanour seemed to help establish relationships by indicating that the nurses were approachable.

Being enthusiastic and energetic was an important characteristic identified of outstanding nurses. These nurses exuded enthusiasm and a positive energy that

demonstrated a commitment to patient care despite the demands of clinical work. High performing nurses also displayed such characteristics as genuineness and personal warmth. This could be compared to the characteristics described by Carl Rogers (1980), as fostering a helping relationship in a person centred approach to care; genuineness and personal warmth, unconditional positive regard and empathic concern. The importance of a positive, enthusiastic approach to the nursing role concurs with a previous study conducted by Webb and Hope (1995) who identified that patients in general want a warm and friendly style of nursing.

A professional image was also evident in the outstanding nurses' behaviours and presentation. Their grooming and dress projected a general aura of professionalism which was evident in statements about their professional dress standard. Professionalism is defined as "the conduct, aims, or qualities that characterise or mark a professional conforming to technical or ethical standards of the profession" (Merriam-Webster OnLine, 2010). It is widely accepted that an individual's perceptions should be based on what a person knows rather than how he or she looks. However, there is an expectation that nurses are professional in manner and *appearance* as first impressions transmit powerful messages. This is a topic that has been overlooked in contemporary nursing research, with a search of the literature revealing mainly descriptive research, opinion and theoretical papers regarding aspects of professionalism. Two research reports were found where standard of dress and perceptions of patients and families were studied. Both studies confirm that the nurse's image conveys messages about the nurse's professionalism (Albert, Wocial, Meyer, Na & Trochelman, 2008; DeKeyser, Wruble & Margalith, 2003). The participants in both studies preferred that nurses wore more formal dress. Importantly, in the first study patient and visitor participants in acute care settings (n

= 390) identified more professional nursing traits when showed pictures of nurses in white formal uniforms than scrub style uniforms. These image traits included confident, competent, attentive, efficient, approachable, caring, professional, reliable, cooperative and empathetic. The white formal uniform image also reflected the highest level of nurse professionalism as indicated by the scores received and was also preferred by older patients aged ≥ 70 years.

How people respond to each other and the creation of a positive patient care environment may be affected by poor presentation skills in dress standard and communication. In this current study it was evident through the comments of participants that the less well presented nurse was perceived as not taking enough care of their own presentation, suggesting that perhaps they would not take enough care with patient care.

Managing Self and Others

Outstanding nurses were noted for their ability to self manage, and their ability to manage the behaviour of others effectively particularly when the circumstances were difficult such as managing aspects of poor staff performance or patient behaviour. They were also very effective managers of the ward environment, especially when they were working as the shift coordinator. The ability to be self regulating and manage novel and complex problems is one of the key markers of a professional, with others being technical and interpersonal skills (Schön, 1987). They demonstrated good leadership and management skills and the health professionals reported being 'happy' when these nurses were on duty. This was also true for patients who stated that they were pleased when an outstanding nurse was allocated to them. Outstanding nurses were noted to be good advocates for their patients and also their colleagues.

Important behaviours of outstanding nurses identified in the current study were the ability to remain calm and to cope relatively easily with patient and ward situations which were considered to have the potential to destabilise another health professional with less coping skills. This coping ability in difficult situations is essential in nurses as it improves their effectiveness in an increasingly complex and changing health care work environment. The nursing literature identifies the main causes of stress in Australian nurses as work overload (Chang et al., 2006; Healy & McKay, 2000; Pinikahana & Happell, 2004), role ambiguity (Chang & Hancock, 2003); conflicts and experiences of aggression at work (Farrell, 1999; Farrell et al., 2006; Rodney, 2000). Role ambiguity was not noted as being an important finding in this study, however there were accounts of work overload and the disruptive and aggressive behaviour of patients and staff being a potential source of stress for nurses. While the outstanding nurses coped with these situations with apparent ease the nurses who performed at what was perceived to be a good level did not manage these situations as well with a number of accounts of good nurses responding poorly when faced with staff behavioural issues or when the workload increased above the usual level. They then needed assistance from other staff to meet patient care needs. It was noted that for satisfactory nurses, there was evidence to suggest that personal stress and work related stresses were related in some way. The home stressors were perceived to 'leak' across into the work environment so that the nurse demonstrated poor communication skills and behaviours in the work environment. This is interesting in light of an earlier study which found that there was a high correlation between personal stress and work related stress amongst nephrology nurses (Lewis, Bonner, Campbell, Cooper & Willard, 1994). Clearly, managing personal stress has a potential impact on patient care.

Being visible and available to others were also valued characteristics.

Visibility meant that the nurses were engaged and involved in the clinical care requirements of patients. The findings indicate that visibility was important to both patients and health practitioners. On one level it meant that the nurse was seen at the bedside and in the ward environment in general and on the other hand it also meant to some that the nurse was visible in meetings and contributing to the ward and its management. While it was apparent that outstanding nurses were visible and actively engaged with ward/unit and patient activity as were good nurses, it was clear from the information given by the participants that satisfactory nurses were not seen in the same light. They were at times difficult to find by professional colleagues and did not contribute to activities such as developing ward policy and protocol or contributing to meetings. They spent the minimum time with the patient and if required to attend meetings were 'voiceless'; that is, did not contribute. It would seem that outstanding nurses were immersed in the totality of their work, while the satisfactory nurses were emotionally distant, leaving the impression that they were not available for the patients or other health professionals.

Forming Personal and Therapeutic Relationships

It was evident from the participants' statements that outstanding nurses maintained a high level of involvement with patients and engaged with staff in a more personal way through the use of their communication skills. The relationship for patients was interpreted as being therapeutic and effective. For staff it was also interpreted as being effective and this group of nurses were seen to have superior relationship building skills.

Good nurses as compared to Outstanding nurses

As indicated in Figure 4.3 there were five major themes describing good nurses. These included Reservations about Clinical Competence; Limitations in Communicating; Inconsistencies in Working Collaboratively; Caring Style and Coping

The findings present clear evidence that nurses who were perceived to be good nurses performed well. At times there were limitations with this group of nurses, with some lacking the detailed specific knowledge and assessment skills of the outstanding nurse and creating the impression that they were ineffective in some of their actions, However there didn't seem to be a compromise to patient safety. On occasion, however, there was a compromise to staff safety, either their own or that of another staff member.

Reservations about Clinical Competence

Participants understood that nursing was concerned with knowledge and complex skills and had an awareness that particular expertise is required. This understanding is sometimes missing when public debates ensue around the perennial question of 'What makes a Good Nurse?' The participants in this study had current or recent experience of the professional care that nurses provide. Former patients all were inpatients for a minimum of three days and all the health professionals in the study had daily or weekly contact with nurses. This enabled the participants to comment from a more informed knowledge base than is sometimes the case in the more general and public sphere. The good nurse was identified by the participants as being clinically competent but having some limitations. Examples of areas of clinical competence limitations included managing patient behaviour, assessing wounds,

managing some technology and teaching and educating patients. Educating patients was not undertaken by this group of nurses as they lacked the specific knowledge needed but had knowledge of a more general nature. The example of the registered nurse suggesting the patient do pelvic floor exercises but failing to explain what these exercises were exactly, illustrates this.

Limitations in Communication

The communication skills of good nurses were seen as being less than the outstanding nurses. There were clear perceptible differences. The good nurse was often seen to be less open in style, to not engage with people to the level that outstanding nurses did. For example, the nurse may greet a person but may not stop, or maybe only stop for a brief conversation despite their being no competing need for time. The limitation in communication skills extended to interpretation of non verbal cues in some cases. This was illustrated by the nurse in mental health failing to interpret the actions of one of the patients resulting in injury to the nurse.

Inconsistencies in working collaboratively

This study found that good nurses focused their attention on the patients assigned to them and did not relate to the rest of the team particularly well. There is an assumption that working collaboratively improves the quality of care and enhances the outcomes to patients. Collaborative teamwork can be problematic because some nurses will collaborate easily with colleagues while others do not.

Participants reported that some of the nurses functioning at the level of a good nurse failed to communicate effectively to the team members. At times the team's ability to function effectively and efficiently was compromised when the plan for the patient was not communicated. When a member of the team failed to

communicate comprehensively with others, they failed to gain a comprehensive picture of the patient and situation. Furthermore, they were not part of the planning process of patient care and also prevented others from having full access to *their* assessment, decisions and actions. Similar findings have been identified by Freeman et al (2000) when investigating how multi professional teams worked. The ability to participate in teamwork can be compromised when communication skills are limited.

Caring Style

A majority of participants commented that good nurses demonstrated caring and concern for their patients. The good nurse was described as caring but in terms of other professional characteristics participants did not identify any other professional and personal values. Caring is such a ‘buzz’ word and caring has numerous interpretations. Although many health professionals care, it is often considered as an exclusive word relevant only in and for nursing.

The participants used words such as empathy, kindness and concern to explain how the good nurses demonstrated caring. Therefore, while participants were able to explicate in some detail how outstanding nurses conveyed their professional values, for good nurses they were not able to do so. Their professional values and behaviours were encapsulated in this one term ‘caring’ which suggests something less than that which was identified in the outstanding nurses. This suggests that the good nurses did not display their professional values and behaviours in ways that were easily discernable to the participants and in ways that the outstanding nurses conveyed; for example, respect, diligence and compassion. In contrast, good nurses’ performance was described in terms of the lesser and more generic term of caring. Affective and instrumental categories of caring behaviour have previously been identified by a number of researchers (Benner, 1984; Larsson, 1984; von Essen &

Sjoden, 1991a, 1991b; Watson, Deary, & Hoogbruin, 2001; Watson, Deary, Hoogbruin, et al., 2003). In this study participants described affective caring in relation to good nurses. The instrumental behaviours such as physical activities, equipment management and problem solving were not considered as being 'caring'. Good quality care has been previously characterised as individualised, patient focused and related to need and provided humanistically through the presence of a caring relationship by nurses who demonstrated involvement, commitment and concern (Attree, 2001). To this extent the good nurses in the current study were perceived to demonstrate caring in the context of caring relationships with their patients.

Coping

There was a perception by the participants that coping with stressors was sometimes not done well by good nurses. This is in contrast to outstanding nurses, who were described as clear and calm no matter the circumstances. There was data from participants that good nurses were not able to maintain a calm demeanour and Chapter four reports several comments to this effect. A large body of evidence substantiates the fact that nurses suffer from work related stress (Chang & Hancock, 2003; Chang et al., 2006; Farrell, 1999; Healy & McKay, 2000; Pinikahana & Happell, 2004; Rodney, 2000; Winwood et al., 2006). A number of these studies have focused on identifying the main sources of stress; the detrimental effect of stress on nurses' health; and coping strategies used by nurses to cope.

Contrary to those reports identifying workload issues as the most frequent cause of stress, this study revealed other sources of stress. These included sudden arrival of new patients (unplanned admissions) and changes in role. Another difference in studies of nursing stress is that they have all been self report studies,

whereas the findings of this study report on the perceptions of the observer; specifically, the effect of a stressed nurse on the remaining staff. Where the stressor was related to the good nurse's personal life there was an awareness by others that something was amiss, and there was often a detrimental effect on other staff. In moments of stress and pressure this group of nurses may not be able to lead and provide direction for more junior staff, especially when they were in a leadership role such as the shift coordinator/team leader. And as nurse participants reported, they may need direction themselves or others may be required to undertake some of the workload of the stressed nurse shift leader.

There were some interesting findings regarding nurses who were described as being outstanding in some ways, but who were limited in other ways, which led to them being identified as good nurses. One might surmise that the outstanding nurse would probably have skills that would endure across contexts, such as the very experienced orthopaedic nurse moving to coronary care. In this case, the nurse's skills were transferred to the new setting and she was described as having interpersonal understanding, a high level of communication skills, and emotional self control. She was also described as meeting patient needs and demonstrating rather high level skills. However, her lack of coronary care knowledge and specific skills related to coronary care were seen as a limitation that relegated her to the 'good nurse' category. This seemed to indicate that a lack of nursing specialty skills was perceived as an important factor in distinguishing good from outstanding nurses. The issue also draws into question the role of experience. As a good nurse gains experience it is possible that (s)he would become outstanding in that particular specialty area. However this proposition is speculative at best, given that experience is not the only determinant of expertise, and participants were asked to provide a

view at the particular time of the study rather than during a nurse's professional development across contexts.

A number of previous studies and/or literature reviews investigating perceptions about the good nurse have focused on the ethical dimensions of nursing care and nursing as moral practice, particularly in cancer care (Christopher & Hegedus, 2000; Rchaidia, Dierckx de Casterlé, Blaeser & Gastmans, 2009; von Essen & Sjöden, 2003). The current study did not address the moral aspects of good nursing; instead focusing uniquely on levels of performance, and the perspectives of a wide range of health professionals as well as patients and nurses.

Satisfactory nurses as compared to good and outstanding nurses

As indicated in Table 4.6 there were five major themes describing satisfactory nurses. These included: Primarily attending to physical care; Providing a minimum standard of care; Selective caring; Lack of demonstrated problem solving skills and Limited personal and interpersonal capabilities.

Participants believed that when the nursing care provided was mainly physical in nature then the nursing care was considered adequate. The satisfactory nurse was considered safe but not holistic in the nursing care they provided.

Primarily attending to physical care

Satisfactory nurses tended to focus on physical care, and the attention that they gave to the psychosocial aspects of nursing was limited or non existent. This left the impression that the satisfactory nurse was task orientated, principally able to follow a plan of care, much like a job list of tasks, and therefore had a narrow focus of practice. An interesting description of this type of approach suggested that the satisfactory nurse was part of a document driven system, wherein if care was not

listed as part of the plan of care, then it was not given. The comment about documentation of care is interesting, given that often in clinical practice it is the psychosocial and emotional care aspects of patient care requirements which are overlooked on the care plans. Therefore this is the care that is likely to be omitted by the less diligent.

Providing a minimum standard of care

Participants identified the type of care provided by satisfactory nurses as a minimum standard. This issue is not merely a focus on the physical but somewhat of a failure to become engaged with the patient or the full extent of work in the team. Satisfactory nurses were not seen to be involved in the ward activities such as attending meetings and so were also seen to lack engagement at that level.

This group of nurses failed to achieve good work. They were not seen to be striving to do good work and are poor role models for future members of the profession. This is important as student registered nurses are regularly undertaking clinical practica and are influenced and socialised into the role and performance expectations of the registered nurse in part, by the example shown by registered nurses in the clinical areas. If there is an absence of professional role models, our future registered nurses will have little chance of becoming good workers; that is, good or outstanding registered nurses.

Selective Caring

A revealing finding was that satisfactory nurses were selective about the patients they cared for and were sometimes selective about the care they provided to individual patients. The preferred patients were often those who required less complex care. This may have been simply because their knowledge and skill level

was less than the good and outstanding nurses. However, nurses who behaved in this way were often nurses with a number of years of experience who would have had the opportunity to develop skills to provide nursing care to complex patients, yet failed to do so.

The hospital environment is becoming progressively more complex. The less complex patient is increasingly likely to be treated as a day patient, out patient or Hospital in the Home (HITH) patient and there are fewer patients with less complex needs in an inpatient acute care setting. Therefore there is a potential for the patient to be affected negatively by the selective caring of the satisfactory nurse. The participants' accounts suggest that reasons were more about the individual than any contextual reasons.

Providing a minimum standard of care, and limiting care to physical care requirements of patients indicates that satisfactory nurses were not attending to the more complex care needs of patients. The satisfactory nurse tended to be selective when the care required was mundane or psychosocial in nature, when the patient was older or dependent, when it was close to the end of shift, or when the patient or next of kin were challenging rather than pleasant in nature. In contrast, nurses who performed at the outstanding or good level were not reported to engage in selective caring.

No prior studies were identified that provide detail about nurses being selective in the care they provide to patients. There is literature on "good" and "bad" patients and "unpopular" or "difficult" patients (Hahn et al., 1996; Johnson & Webb, 1995; Koekkeoek, Hutschemaekers, Meijel & Schene, 2011; Mayer, 2008; MacDonald, 2003; Sutherland & Gilbert, 2008). These studies do not report on whether the patients did or did not receive care from some or all nurses. The

selectivity of care provided by nurses in the current study is somewhat similar to the impeded care provided by nurses identified by Drury, Bailey, Blackmore and Maltby (2003). Impeded care was provided to a patient with a condition that caused the nurses themselves to react negatively. This detrimentally affected the quality of care given to the patient as some of the care needs were not met (Drury et al., 2003).

The nurses who participated in the study by Drury et al., (2003) were self aware and made attempts to improve their quality of care in subsequent nurse patient interactions. This distinction provides critical insight into the reason for the lack of care and how to address the performance issues. Nurses able to self reflect on their performance may well be more amenable and willing to change than nurses who are not reflective practitioners.

A number of studies have focused on aspects of missed nursing care (Callen, Mahoney, Grieves, Wells & Enloe, 2004; Kalisch, 2009; Kalisch, Landstrom & Hinshaw, 2009; Kalisch, Kalisch & Williams, 2009; Lindstrom & Williams, 2009; Rasmussen, Kondrup, Staun, Ladefoged, Kristensen & Wengler, 2004). Missed care was defined as any aspect of required patient care that is omitted or delayed (Kalisch et al., 2009). The antecedents of missed nursing care were identified by the researchers as external to nurses and therefore created a need for the nurses to decide what care will be provided. However, nurses' internal processes such as group/team norms, priority decision making, internal values and beliefs and habits may also have an influence over a nurse's decision to omit care. The literature suggests that missed care is universal and that it is underestimated. An interesting finding of a study conducted in the United States by Kalisch et al., (2009) was that nurses with associate degrees (ADNs) reported more missed care than degree and diploma prepared nurses. The authors suggest that this may be due to the task orientation of

this level of nurse, wherein they fail to follow a more integrated approach to patient care.

Task orientation among satisfactory nurses was also found in the current study, Participants who were patients often resigned themselves to waiting to the shift handover in the hope that the oncoming nurse was one that performed at a more comprehensive level. In contrast to this level of nurse, the outstanding nurses provided care which was comprehensive and participants indicated that they attended to all care requirements including all the personal care requirements such as heel and mouth care.

Lack of demonstrated problem solving skills

For the patient experiencing problems, the satisfactory nurse was able to refer the problem to an appropriate person such as the shift coordinator. However, they were not proactive about identifying solutions. As a consequence, patients would need to wait for a response or attention to the problem from another nurse, or health professional. Patient care was not seen to suffer, but it was often provided through the problem solving and critical thinking of others.

Even where satisfactory nurses were able to identify that a problem existed, they referred the problem to a senior person or other health professional. This, of course, is better than not identifying the patient problem at all, however, this level of skill is inadequate in today's complex clinical environments, as it places the burden and responsibility on others. In demonstrating a lack of critical thinking and clinical judgement, their attitude to patient care often described as 'just getting the job done'.

Little research has been undertaken investigating nurses who do not meet the role performance required of a registered nurse. A few studies have investigated the 'not so good' (Attree, 2001; Fagerström, 2006) or 'good enough' (Allan, 2001). Del

Bueno (2005) described the lack of critical thinking in new graduates as being at crisis level. Only 35% of new graduates at entry into the profession met the criteria for critical thinking which included using clinical judgement within a specified timeframe. What is of concern in the current study is that nurses performing at the satisfactory level and who were not necessarily new graduates are limited in their ability to critically think, use clinical judgement and problem solve as perceived by the participants. Moreover they are also role models for students on their educational journey and thus helping to perpetuate these values, and behaviours in nurses of the future.

Limited personal and interpersonal capabilities

Satisfactory nurses were identified as being the group of nurses who were more likely to have problems with how they communicated with patients and staff. This also led to difficulties forming appropriate and effective interpersonal relationships with their colleagues and patients. Satisfactory nurses exhibited a number of attributes which included: inattentiveness and disengagement toward patients, they lacked approachability and were more likely to have a problematic style of engaging with patients and staff.

How patients experience care is central to the way patients and staff view the quality of care delivered. Little emphasis was placed on the technical aspects of care by the patients in this study. In particular, there was an assumption by patients that nurses were competent about the technical skills and tasks of nursing, otherwise the nurse would not be permitted to be on the job. There was no evidence that satisfactory nurses engaged in the type of interpersonal interactions that made patients feel cared for, which is often stated as being the essence of caring (Benner & Wrubel, 1989; Parse, 1995; Watson, 1985). The satisfactory nurses seemed

disinterested and disengaged and were not approachable. Interpersonal relationship skills, and the interactional and interpersonal aspects of care are an indicator of quality care. Kralik et al., (1997) reported that surgical patients found the ‘engaged’ nurses acknowledged the physical and emotional dimensions of the patient, while the disengaged nurses provided care which was depersonalised and avoidant of social contact. Kralik et al.’s findings concur with previous empirical research indicating the significance of constructive, encouraging and supportive communication (Thorne, 1988).

Overall, there was a perception that care was safe, but not holistic. Satisfactory nurses followed the plan of care, but did not develop the care plans, so they were dependent on the skills of other nurses. They were not involved in risk taking in terms of patient care, they delivered minimal care and, by their interventions, they did no harm. One participant summed up the situation by concluding that if the care that was prescribed was given and the nurse made the patient comfortable then this she thought was ‘very satisfactory’.

Shared Understandings

As mentioned at the outset of this discussion there was a high level of concurrence in the way participants perceived the performance of the various levels of nurses. Participants clearly described with remarkable similarity that the nurses who performed at a satisfactory level attended primarily to the physical care requirements of the patient and provided what they perceived to be an acceptable level of care. Numerous participants who included mental health nurses, general nurses, doctors, patients and allied health professionals used similar terms in reporting the satisfactory nurse as having a task like approach to the care

requirements of the patients and similar words were used such as “*just doing the job*”, by participants implying a minimum level of effort, commitment and engagement. There was a consensus amongst participants that this minimum level was acceptable and adequate. To be able to undertake little more than tasks suggests that the nurses identified as performing at a satisfactory level were performing at a level somewhat less than the required performance of a registered nurse, possibly commensurate with an enrolled nurse. What is alarming is that both the health professional and former patient groups identified this level of performance as adequate. One participant (N6) suggested that performing at a satisfactory level was somehow unsatisfactory; and that this was less than the required level of performance.

The health professionals in the study identified that satisfactory nurses were able to provide patient care when care requirements were routine. However, they needed assistance when complexity of care requirements increased. They also identified their lack of problem solving. This makes satisfactory nurses dependent on other registered nurses who are able to critically analyse patient situations and problem solve difficulties. It was noted previously that unusual events and problems are *likely* (emphasis mine) to arise in acute health care settings. If their work is confined to tasks rather than anticipating and addressing problems, one could conclude that they were providing substandard care, as good nursing care consists of more than the competent performance of nursing tasks.

A study of non-expert renal nurses also found that some nurses have limitations in critical thinking and problem solving (Bonner, 2007; Bonner & Greenwood, 2006). Researchers found that renal nurses needed assistance with complex patient care and although able to follow rules about renal nursing, they

needed guidance from other nurses to perform. An important difference between the renal study and the current study is that in the study of renal nurses, the non expert nurses were reported as feeling insufficiently competent to perform many specialized nephrology nursing tasks. In the current study there is no evidence to suggest that the satisfactory nurses were self aware about their limitations or the impact on others. Without this awareness, reflection may not occur and consequently required changes to performance are unlikely.

It was also clear that health professionals and patients were able to identify that satisfactory nurses had limited interpersonal relationship building skills. There were many aspects of poor communication that participants described which included abrupt manner of speech, indiscretion, expressing lack of confidence particularly in the presence of patients, intimidating to approach, less approachability, forceful style of communication and inappropriate conversations occurring at the patient's bedside, or within earshot of patients and visitors. Many of the nurses had been part of the ward/unit for some time without any change occurring in their performance. Therefore the length of time some nurses were practising did not have a discernable impact on their performance. This suggests that for some nurses, experience does not play a role in improving performance.

This study did not investigate the nature of expertise or ask the participants whether the outstanding nurses were identified as experts in their field. However, the findings suggest that the outstanding nurses demonstrated expertise through their specific knowledge and skills and pattern recognition. Often an expert is recognized when they demonstrate that something falls outside the normal pattern. An example of this was identified by one of the participants when a larger than usual dose of a medication was prescribed and the outstanding nurse recognized and responded to

the drug order which did not fit a usual prescribing pattern. Being an expert implies that a person has a specialized body of knowledge and skill, extensive experience in a field of practice and highly developed levels of pattern recognition (Jasper, 1994). Further, and importantly, the expertise is *recognized by others (emphasis mine)*.

Differing Perceptions

The participants' shared perceptions and understandings about what constitutes satisfactory, good and outstanding nurses has been discussed in the preceding sections of this chapter. Some differences in perspectives that did emerge from the analysis appeared to have arisen from participants' prior experience with nurses and nursing care. For example, participants who were former patients were not able to comment about the performance of nurses when the nurse was not engaged in patient care at the bedside. They did not comment on the registered nurses beyond their direct contact with the nurses or the direct care they observed when nurses were interacting with other patients when located in a shared hospital room. Therefore they did not and could not comment on any indirect care that nurses undertook. Nor could they comment about any other aspects of the registered nurse role. There were three patients who commented that they were aware that there was a nurse in charge of the ward but were not able to comment about the person's abilities as a ward coordinator or how well the ward was organised. On the other hand, the health professionals had extensive recollections of the nurses as coordinators of the ward or unit, and as coordinators of individual patients' care and treatment needs. For the patient the most significant nurse was the bedside nurse. Some participants' comments may have related to differences in people's personality or practice styles. Differences in work style may lead people to think that the nurse, for example,

working at a slower pace is unsure or lacking confidence when the nurse may have been performing her role responsibilities carefully and thoroughly. There may have been some participants who valued efficiency and therefore held in more positive regard the nurse who worked quickly. However, the accounts from participants have been remarkably similar about many aspects of the different levels of nurses but some differences did arise.

Nature of Communication Limitations

Health professionals indicated more frequently than patients that poor communication was one aspect of the satisfactory nurse's performance which was less than optimum. Patients were likely to describe the nurse's manner or style as the problem e.g. less communicative or a clipped manner. Health professionals were more likely to make comment about the content of the conversation e.g. inappropriate conversation, complaining, lack of information when seeking clinical information or poor nurses' handover and short conversations.

Making Critical Professional Judgements to Solve Patient Problems

Satisfactory nurses were identified by health professionals as being nurses who could manage patient care providing that patient problems did not develop. When this occurred then the satisfactory nurse needed to seek assistance from others. Health professionals viewed the inability of this level of nurse to problem solve and make critical judgements related to patient problems to be a significant issue and performance deficit. However, former patients did not comment on the nurse's problem solving skills. There was recognition by former patients that satisfactory nurses were task orientated but they did not comment negatively if another nurse was consulted regarding problems. There may have been an underlying assumption by

the patients that problems, should there be any, would be identified promptly and the right action taken. The fact that another nurse becomes involved may not be seen as an indication of lack of knowledge and skills or problem solving ability in the case of the satisfactory nurse, but rather a less experienced nurse seeking out or reporting to the senior nurse or the nurse in charge. This would then be seen in a positive light. One participant (Pt 6) did comment that nurses consulting each other about his care was advantageous. The fact that their bedside nurse may not have capabilities regarding problem solving and critical thinking was not discussed by the former patients. This may be as a result of previous practices undertaken in nursing where the most junior nurses were at the bedside and were required to report to the nurse in charge. This practice continues to be evident to patients and the need for problem solving and critical analysis skills of bedside nurses is not well understood by the general public.

Studies show that the public views caring as the primary and highly regarded role of nursing (Hemsley-Brown & Foskett, 1999; Tang et al., 1999). Patients also expect competent nursing care. However, knowledge regarding the role, responsibilities and expertise required of the registered nurse is not well understood by the general public, including those who have been patients. While the nursing profession understands that advanced knowledge and complex skills are now required in patient care, the general public lacks an awareness of the nature and extent of nursing expertise in modern nursing (Fealy, 2004).

What is somewhat alarming is that both the health professional and former patient groups described nurses with a task orientation as being deficient but adequate. While recognising that task orientation was deficient, the patient group

was not able to identify that critical thinking and problem solving were part of the required repertoire of skills of *all registered nurses* (emphasis mine).

The newly graduated registered nurse may be seen to have less critical thinking ability in relation to solving patient problems and therefore needing to seek assistance from a more experienced nurse. In the current study, the overwhelming number of nurses described as not being able to problem solve were registered nurses who had been practising for a number of years. This suggests that the problem is longstanding and although the extent was not quantified in this study the reports from participants suggests that there may be a significant number of registered nurses who lack these key skills necessary to carry out their role as registered nurses. This gets to the core of the question about the extent to which experience creates excellence. These experienced nurses lacked critical thinking which is crucial in today's complex health care environment. While registered nurses should not be required to solve all the problems, they should be able to solve those within the registered nurse's scope of practice. Interestingly, there is a tension between the idea that we should be able to solve nursing problems and team work. It is important that nurses not overestimate how many problems they can solve and can identify clearly which professional group should solve a patient problem when it falls outside the registered nurse's scope of practice. There was evidence to suggest that the outstanding nurses referred to in this study were able to manage patient and staff situations well, or refer and consult other health professionals appropriately.

Gradations in Participant Perceptions of Performance

The good nurse was clinically responsive to patients and was able to identify what was needed in a particular situation and also anticipated care requirements. The good nurse was proactive, responding appropriately to patient situations and able to

take action to prevent problems occurring. As discussed earlier the good nurse was considered to be patient focused and performed well in the role of the nurse clinician. However there were limitations in their performance; the nature and type of limitation was perceived differently. Health professionals, but not patients, commented on the inconsistencies in working collaboratively.

The outstanding nurse was described as someone who was patient focussed and had situational awareness. They were able to provide a high standard of patient focussed care as well as being able to lead ward staff in both routine and unexpected situations in a manner which was calm and decisive. They were identified by the participants as having far superior knowledge and skills compared to the other two levels of nurses.

The depth of descriptive data on outstanding nurses lends originality and significance to the findings. A study focusing on a minimum of competencies and standards could not possibly obtain the rich data that came from these interviews, which described in great flourishing detail how the nurses were perceived. This degree of rich data validated the choice to conceive and undertake the research as an interpretive study with the intention of eliciting information from people who were or had been sufficiently close to the registered nurses to provide in-depth detail and understanding. Interviewing a wide range of participants also revealed the full extent of the role of the nurses which may not have been evident to one discrete participant group. The different participant groups were necessarily attuned to different demands and circumstances when engaging with nurses and therefore a broader and fuller picture was revealed. The findings have revealed that some registered nurses in clinical practice are able to embrace the complex nature of professional nursing practice while others are yet to do so.

Conceptual Issues Related to the Findings

Graves (1970, 1974) in describing humans, has stated that it is possible for humans to exist at different levels (a brief description of Graves' ideas is provided in chapter 2). It has been clearly shown in this study that the participants, having observed the nurses in context, were able to describe registered nurses in the work environment as providing different levels of care. On one level this may conform to the idea that nurses progress in a linear fashion in their skill acquisition as described by Benner (1984). Within this type of model nurses performing at different levels within healthcare facilities can be understood clearly. However, this study establishes that some nurses begin their professional life at a higher level than what was implied by Benner's (1984) work, while others plateau, never progressing beyond a certain level of care which participants described as satisfactory.

Another important idea raised by Graves was that at any given level, an individual exhibits the behaviour and values characteristic of people at that level. This study has revealed that there were observable affective behaviours, and, at some levels of performance the professional and personal values of the registered nurses could be identified. Most previous studies have focused on knowledge and skills, which have tended to overshadow the attitudinal behaviours and values of nurses. However, participants in this study have clearly described the attitudes and values present in the outstanding nurses, less so in the good nurses and did not offer highly positive descriptions when referring to satisfactory nurses. The satisfactory nurses had a limited number of competencies and skills but did not seem to have the personal and professional development, nor demonstrate a capacity to be responsive in a manner commensurate with the requirements of complex patient care and the complex work environment.

The capability literature identifies effective practice as including ethical practice, clinical knowledge and competence, and the ability to cultivate productive partnerships with other health professionals to provide holistic patient care. These abilities, and the requisite professional and personal attitudes were clearly evident in the nurse operating at the outstanding level, but less evident and/or missing in the nurse performing at a satisfactory level. Sen (1993) explains that capabilities are opportunities to achieve what on reflection, an individual considers valuable, particularly where an individual is given the opportunity to achieve. There was a perception by participants in this study to suggest that nurses performing at the lower level did not value nursing or exercise self agency to achieve at a higher level. Therefore, their poor performance could be attributed to personal values and factors.

Study Limitations

The participants in this study were observing the nurses in context. Aspects of the context such as the situational factors of the work context, organisational factors, organisational culture, organisational subcultures, educational background are all extraneous factors and can influence a nurse's performance. These can be seen as factors which reduce the opportunities for nurses to achieve. Although it would have been beneficial to evaluate the influence of these factors, it was beyond the scope of the study. However, it is important to note that previous studies have identified that there is a correlation between work culture and such factors as performance, commitment and quality of care (Lok & Crawford, 2001; Lok, Westwood & Crawford, 2005; Kangas, Kee & McKee-Wardle, 1999). However, in this study there was ample evidence to suggest that for some nurses, they were able to achieve and be capable practitioners irrespective of any system constraints.

The findings have confirmed that registered nurses can clearly be perceived as having different levels of professional practice. They also indicate that there are high performing nurses in the acute mental health and general care sector who are capable practitioners who have a high level of self efficacy, appropriate social and communication skills to work well in teams and the ability to apply competencies in common and novel situations. They have achieved excellence in their practice. They were considered to be expert in practice and knowledge. They were capable practitioners who were able to adapt to change and changing situations. Nurses who performed at lower levels were lacking in some areas of knowledge and skills. This calls into question whether the nurses who were perceived to be performing at a satisfactory level lacked a number of competencies and failed to meet the ANMC competency standards.

Meeting the ANMC Competency Standards

The national competency standards for registered nurses were developed by the Australian Nursing Council in the early 1990s, now the Australian Nursing and Midwifery Accreditation Council (ANMAC), and these are used widely in Australia in Schools of Nursing to develop curricula and assess student and new graduate performance. The standards reflect the minimum skill and knowledge required by beginning practitioners, nurses wishing to retain registration and for assessing nurses educated overseas. Registered nurses are required to reflectively evaluate their practice against the core competencies. These standards are broadly defined and generic, designed to provide a framework for assessment across many contexts of care. The domains of the ANMC competency standards for the registered nurse are: (i) professional practice; (ii) critical thinking and analysis; (iii) provision and

coordination of care; and (iv) collaborative and therapeutic practice. The scope of professional practice includes those competencies specific to legal and ethical aspects of patient care, for example demonstrating an adequate knowledge base, accountability for practice, and protection of individuals. To demonstrate minimum competency in critical thinking and analysis the beginning nurse must be able to self appraise, engage in professional development and incorporate research into clinical practice. The third domain, provision and coordination of care, includes those competencies which relate to the assessment, implementation and evaluation of care. Collaborative and therapeutic practice addresses those competencies which allow for the establishment and continuation of appropriate and professional relationships with colleagues and patients i.e. the nurse has adequate interpersonal and communication skills to maintain professional relationships for the benefit of the patient.

There was little evidence provided by the participants to suggest that the satisfactory nurse met all the elements of care required to achieve the competency standards for a beginning practitioner as set out by the ANMC. Many participants in the study commented that satisfactory nurses were very task orientated. Professional values and the roles and responsibilities of nurses are represented by international and national codes of ethics in nursing. The professional expectations of nurses are clearly defined in national standards and codes developed by the Australian Nursing and Midwifery Council (ANMC) which include: the National Competency Standards for the Registered Nurse, Continuing Competency Framework, the Code of Ethics for Nurses in Australia, and the Code of Professional Conduct for Nurses in Australia (ANMC, 2006, 2008a, 2008b, 2009). Among the nurses described as satisfactory there was insufficient evidence of sound knowledge and clinical competence to deal with complexities of care. The profession understands nursing to

be concerned with advanced knowledge and specific skills. However, the recipients of nursing care reflected a lack of awareness of nursing expertise, had low expectations about nursing performance and accepted a much lower level of competence than that which should be expected from a registered nurse. More alarming is that the registered nurse participants and other health professionals also had similar explanations and expectations about satisfactory nurses, as well as the performance limitations of those identified as good nurses.

In terms of the spiral model of development (Graves 1970, 1974) this means that there is no predictable linear sequence of progression towards attainment of an ideal state; that development is cyclical in nature. Individuals are themselves developing, therefore for nurses, the level of personal, behavioural and value attainment impacts on the level of professional attainment. For nurses of today and the future performance requirement does mean having the capability to function effectively in an increasingly complex world and health care environment where greater complexity of 'thinking, being, knowing and doing' is required to meet patient, professional and health system requirements. Therefore, for nurses the attainment of higher levels of performance will only be achieved through continuous *personal* (emphasis mine) and professional development opportunities. These opportunities must be provided and undertaken if professional behaviours are to be maintained and /or enhanced. Ongoing education, mentorship and in particular accurate, regular and honest self and peer assessment of professional skills is essential.

Summary, Recommendations and Conclusions

Summary

This study has revealed that there are highly capable nurses in acute general and mental health care agencies at the ward and unit level who practise at an advanced level. The study has identified the need for further studies to operationalise the ANMC Competency Standards and the domains of practice in their entirety. Such research would ensure that the expectations of the regulatory authorities were aimed at excellence rather than mediocrity.

The outstanding nurses were admirable for the quality of their work. They practised in a way that demonstrated that they were highly competent and skilled in their nursing practice. There were considerable comments about the ability of outstanding nurses to demonstrate a high level of knowledge and skill in undertaking their nursing activities. Their performance went beyond being competent. They demonstrated discipline specific knowledge and skills, had a high level of interpersonal skills which enabled them to manage others, and develop good relationships with patients and colleagues. In terms of the theoretical framework, these outstanding nurses were clearly the type of people with a high level of personal capability. They were also self managers who demonstrated a number of key self regulation factors, or 'self-agency'. These factors included high level skills in critical analysis, written and oral communication, planning, engaging effectively in teamwork, and solving complex problems. They also had the capacity to tackle unfamiliar problems and new situations in novel ways. Their clinical performance clearly demonstrated that they exceeded the ANMC competency standard frameworks. In the important area of patient and family education, the outstanding

nurses were the only level of nurse who provided comprehensive patient and family education.

It was disappointing that not all nurses in the study were practising in such a holistic way. Some of the nurses, particularly those operating at the satisfactory level, as described by the participants in the study, did not meet the national competency standards for the registered nurse. The good nurses were reported as providing general information, while there was no indication of the satisfactory nurse providing any patient and family information or education. The nurses performing at a level described as satisfactory were performing at a level far less than the outstanding nurses and the competency standards required.

Recommendations

The findings of this study suggest a number of recommendations to enhance nursing education, improve clinical performance in the practice setting and extend nursing knowledge through further research. An overarching recommendation is that there needs to be a national discussion on how patient centred care can become the primary focus of patient care by all nurses. This approach will reflect a valuing of the patient/client as the focus and centre of care as opposed to an exaggerated focus on organisational outcomes and procedures, which can detract from patient care. A national dialogue on patient-centred care will better serve the profession as well as the public by linking the realities of nursing practice with the ANMC competency standards for the registered nurse. Meeting the ANMC competency standards has become a national imperative for registered nurses and those entering the profession. However, these are minimum standards of practice. The findings of this study suggest an additional imperative to address the problem of underperforming nurses in the profession, which may include a discussion about how to identify students

about to graduate who may underperform in the fully fledged role of a registered nurse.

There is a need to articulate the progress made in professionalising the role of nurses to the profession and general public. This needs to be done in a way that nursing doesn't yet again become embroiled in the 'nursing as a vocational calling' or the return to depicting nurses as 'angels'. This discussion should include a reaffirmation of the high standards of knowledge and skills of the profession's good and outstanding nurses. The outstanding nurses exemplified both personal and professional capabilities in their practice, and to ensure succession planning, these need to be modelled clearly to the younger generation of nurses and nursing students. The outstanding nurses were compelling role models. In contrast, the nurses described as satisfactory compromise the standing of the nursing profession through the poor quality of their work, which seemed to just barely meet the competency standards. In effect, they de-professionalise nursing.

Recommendations for Clinical Practice

A number of recommendations are suggested to improve registered nurse performance and enhance clinical practice.

Performance appraisals which reflect ANMC standards.

In today's regulatory environment, the satisfactory nurses who were perceived to be performing at a satisfactory level would not likely meet the ANMC competency standards for registered nurses. A logical conclusion is that their substandard level of performance may not be isolated and would not just happen overnight; and therefore this seemingly tolerance of low standards of performance is troubling. This leads to the recommendation for annual performance appraisals,

which are a nursing management strategy to ensure that there is no slippage of skills and knowledge.

Regular performance appraisals will assist in the assessment of satisfactory nurses who often failed to provide comprehensive care to complex patients despite having some years of nursing experience. Reflective practice records where nurses demonstrate improvement in practice over a period of time may lead to an improvement in competency for patients across the whole continuum of care. Accurate, regular and honest self and peer assessment of professional skills is essential.

Team leaders as directors of patient care

All patients in the acute care environment have access to a high performing registered nurse who, irrespective of whether (s)he is the nurse providing direct patient care, is the registered nurse *directing* care. *All* patients should have direct access to a registered nurse who has a high level of capability and is able to assess, plan implement and evaluate care. The patient should also have a nurse directly responsible for their care who is able to problem solve, critically think and analyse complex patient problems and capable of functioning well in their role in an increasingly complex environment. The current ward practice styles in the acute care sector suggest that all registered nurses are autonomous practitioners who may refer to the ward/unit shift coordinator to address routine and complex patient issues. Yet, the patient may be cared for by a nurse who is working at a minimum standard and therefore fail to receive the level of care to which they are entitled. The nurses who are underperforming can, as autonomous practitioners, choose whether they consult or not consult more capable nurses, and therefore the patient may remain at the

mercy of an underperforming nurse. When there are underperforming nurses on the ward the patient may or may not receive the care they need.

Current practice is that there is one team leader on the ward on a shift by shift basis responsible for the clinical care that's occurring for all the patients who are increasingly more complex. Concurrently the intensity of work has increased making it difficult for the shift coordinator to oversee and that situation is made more dangerous or risky for the patient when there are underperforming nurses there. This may necessitate the reintroduction of team nursing with leaders, senior and junior members. The team leader position should be a promotional position to enhance the importance of the role.

Development of practice models

The development of professional practice models to guide nurses on the requisite practice standard is an imperative to ensure patient focused care. The nursing profession has had considerable success in recent years in identifying best practice in patient care, utilising the principles of evidence based practice to identify the most appropriate nursing interventions for patient care. However, practice models on integrating patient care within the practice context have not been well explicated. Many factors can influence the practice context. These include differences in nursing specialty, nursing values, patient acuity, organisational culture, location of facility, presence or absence of members of the multidisciplinary team, and style of nursing leadership. This level of variability may mean the development of different frameworks and practice models rather than a single practice model. The Essentials of Care Project in New South Wales is one such project (<http://www.health.nsw.gov.au/nursing/projects/eoc.asp>) currently underway.

There is a need to explore a range of practice models which place the patient at the centre of care.

Mentoring potential clinical leaders at ward/unit level

The use of outstanding nurses to be mentors to high performing junior nurses and student nurses is an important recommendation of this study. For new staff, facilitators to the routines of the ward and providing information about the functioning of the ward were identified as being the nurses perceived to be performing at a good level. The outstanding nurses were role models but at some distance. Of particular importance is the need for role modelling of the affective component of competencies; knowledge and skills have tended to overshadow the attitudinal behaviours and values. There is much talk of the leadership gap in nursing and concern about from where will the next group of leaders for the profession come. There needs to be earlier and stronger recognition of who the potential leaders might be and for them to be fast tracked. There is a need for mentoring in practice. Mentorship of registered nurses needs to commence in the transition year with new graduates identified as potential leaders.

Recommendations for Education

By the late 1980's preregistration education for nurses was solely being undertaken at the university degree level in Australia. The shortages that have occurred in workforce numbers have placed pressures on universities to increase enrolments to meet workforce requirements. The looming departure of the 'baby boomer' generation of nurses will again place pressure on educational facilities to attract students into nursing programs in large numbers. Therefore responsibility is placed on educational facilities to expand, however this expansion should not come at the expense of improvement.

Enhancing critical thinking, analysis and decision making skills

The complex demands of practice place greater responsibility and emphasis on the need for nurses to be able to critically think and analyse situations to come to the best possible decision given the circumstances at hand. The ability of only some nurses to deal with the complexities, presents a crisis in education. Building knowledge and teaching from simple to more complex, element by element, as well as dealing with that complexity is an educational imperative. Students have to be exposed to the complexities of practice, typically in their clinical placements, where they get a sense of how everything fits together. There is a failing in our current system intermittent practicum experiences leads to a fragmentation of their understanding. There must be greater emphasis placed on educating nurses to deal with increasingly complex patients within complex environments and systems to enable the registered nurses of tomorrow to critically think and operate effectively in acute care environments of today maintaining patient safety and quality of care.

Providing funded specialty education for acute care nursing

Acute care nursing needs to transition to specialty care to meet the standard of safe and effective care. It is clear that the outstanding nurses were experts and that this expertise had a foundation in their knowledge and skills about their specific practice area. A general nurse may not be effective in a health care system with increasing complexity and with ward areas increasingly being designated by the specialty of practice. The good nurses in this study were described as having a more general knowledge, but were not described as expert. With the increasing complexity of patients and the health care system, acute general and mental health care nurses require specialised knowledge and skills to safely and effectively care for their patients. Therefore properly funded government supported programs in all areas of acute care is crucial. This would allow registered nurses to continue gaining

knowledge and skills in structured programs while gaining clinical experience, which will increase the knowledge base of the entire nursing workforce. This will help fast track early career nurses, from where the next generation of expert nurses will come.

Emphasising the role of nurses in patient education

Nursing education programs should place greater emphasis on the nurse's role in educating the patient and family. In this study the outstanding nurses were commented on as undertaking staff, patient and family teaching. However, participants did not comment that this important activity was undertaken by registered nurses performing at good and satisfactory levels.

Re examination of the essence of nursing care should be an ongoing, reflective exercise for all nurses. Caring is a combination of knowing 'that' and knowing 'how'. In terms of patient education, this means that all nurses must be equipped with high level knowledge and the skills to access evidence for timely, relevant and appropriate patient education. The patient is the primary focus of nursing practice and knowing 'how' in patient education is about knowing how to get the information across to the patient prior to discharge. With decreasing lengths of stay there is an imperative that all nurses are adept at patient and family education and therefore place the requisite emphasis on patient education as an essential component of the role of registered nurses.

Recommendations for Further Research

Further research needs to be undertaken to further explicate the value adding that excellence in nursing practice brings to patient care. Previous studies have established that higher ratios of skilled nursing staff compared to unskilled staff improves patient outcomes. However, investigations have not been undertaken to

establish that excellent nurses improve patient and organisational outcomes above nurses performing at the level of good and satisfactory.

Explicating the nurses' role in relationship building

The importance of relationship building in patient care is an important area of research that needs to be extended as a way of explicating further the role of nursing. Therapeutic interactions are at the foundation of nurses' professional activities. There is a need to investigate issues and strategies for communication, relationship building and therapeutic interactions. It was clear in this study that outstanding nurses were valued for their abilities in the areas of relationship building, not only with patients but also with other members of the health care team, which has the capacity to enhance teamwork and thus improve the quality and safety of patient care. Additional research should also be undertaken to investigate the impact of styles of management and ward or unit culture as constraints and facilitating factors on these two crucial areas.

Investigating approaches to managing the disparities in performance of registered nurses.

It can be expected that in workplaces there will be differences in performance levels amongst the same professional group. However, clearly, the disparities in performance identified in this study suggest that for some nurses there needs to be strategies developed to manage poor performing nurses whose performance is seemingly tolerated. Research needs to be undertaken to investigate how best to manage and diminish these disparities in performance. Of particular note in this study is that the nurse providing satisfactory nursing care was very task orientated and likely to omit psychosocial and emotional care aspects of patient care. Therefore approaches to ensure that this important aspect of care is undertaken need to be

identified. In addition, ways of motivating this group of nurses to provide care to all patients in particular complex patients need to be investigated.

Explicating the registered nurses' role in effective teamwork

Further research needs to be undertaken on teamwork. Clearly, some nurses have a greater ability to function well in a team, as the outstanding and good nurses demonstrated in this study. To ensure quality of care and patient safety, nurses need to be consummate professionals, working with other health professionals to secure quality improvements and systems that fit well with the complexity of contemporary care. The complex demands of practice place greater responsibility and emphasis on the need to be client centred, including the family as client, and cognisant of continuity of care issues. The patients now admitted to acute care often have multiple health issues requiring good team work with a multitude of health professionals. It was established in this study that outstanding nurses functioned well in teams and were respected by their colleagues in nursing and other health professions.

Using the ANMC Competency Standards to assess performance in the clinical setting

This study established that there are a number of registered nurses in a multitude of clinical settings who do not meet all the performance requirements of a registered nurse as set out by the competency standards. The performance of the nurses was presumably being assessed using the health care facility's performance appraisal tools. It is recommended that studies be undertaken using the ANMC competency standards as the means of assessing performance in the clinical settings to establish the extent to which registered nurses are meeting the standards or not in clinical practice. Initially, case studies of exemplary practice can be undertaken as a measure of performance on both the ANMC competency standards and the health care

facility's appraisal tool. This will help establish validity of the tools used and ensure their relevance to the evolving conditions of clinical practice.

Conclusions

A number of factors pose a challenge for registered nurses to deliver care which meets the required professional standards. These include the nature of nursing work in its many contexts, the complexity of disease processes and medical and nursing treatment regimes, the increasingly complex technology deployed in patient care, changing consumer expectations and constraints of a burdened health care system coupled with staff shortages. As a minimum standard of performance all nurses once registered should in their annual performance appraisal meet competency standards. However, there is no formal or legislative requirement that the employer/supervisor assess each individual according to the competency standards for registered nurses. Therefore workplaces have developed performance tools based on other criteria usually aligned with job performance descriptions, highlighting the two views of competency previously described by Barnett (1997); an academic and operational view of competency.

The ANMC competency standards and framework for continuing practice are, after all, the minimum competency standards. Registered nurses should be reflective in how they evolve and develop and demonstrate that on a continuing basis in the workplace. In terms of the framework of capability referred to in this study, nurses need to aspire to fill their capacity for higher levels of capability in their practice. Mediocrity in practice is not an expectation in patient care. Neither is

mediocrity an expectation in nursing education. Nurse educators should be teaching to develop excellent practitioners, and therefore accepting minimum standards of achievement as good enough, may not be enough. Nursing needs to research the factors that will create outstanding nurses to provide a guide for nurses to become excellent care providers who utilise a patient centred approach.

REFERENCES

- ACTU/TDC Mission to Western Europe. (1987). *Australia reconstructed: A report by the mission members to the ACTU and TDC*. Australian Government Publishing Services, Canberra.
- Alavi, C., & Cattoni, J. (1995). Good nurse, bad nurse... *Journal of Advanced Nursing*, 21, 344-349.
- Albert, N. M., Wocial, L., Meyer, K. H., Na, J., & Trochelman, K. (2008). Impact of nurses' uniforms on patient and family perceptions of nurse professionalism. *Applied Nursing Research*, 21(4), 181-190. doi: 10.1016/j.apnr.2007.04.008
- Allan, H. (2001). A 'good enough' nurse: supporting patients in a fertility unit. *Nursing Inquiry*, 8(1), 51-60. doi: 10.1046/j.1440-1800.2001.00090.x
- Allen, D. G. (1995). Hermeneutics: Philosophical traditions and nursing practice research. *Nursing Science Quarterly*, 8(4), 174-182. doi: 10.1177/089431849500800408
- Allen, M., Frasure-Smith, N., & Gottlieb, L. (1982). What makes a "good" nurse? *Canadian Nurse*, 78, 42-45.
- Alligood, M. R. (2006). Introduction to nursing theory: Its history, significance and analysis. In A. M. Tomey & M. R. Alligood (Eds.), *Nursing theorists and their work* (6th ed., pp. 3-15). St Louis: Mosby Elsevier.
- Anderson, C. D., & Mangino, R. R. (2006). Nurse shift report: Who says you can't talk in front of the patient? *Nursing Administration Quarterly*, 30(2), 112-122.
- Anderson, L., FitzGerald, M., & Luck, L. (2010). An integrative literature review of interventions to reduce violence against emergency department nurses. *Journal of Clinical Nursing*, 19(17/18), 2520-2530. doi: 10.1111/j.1365-2702.2009.03144.x
- Armstrong, D. (1983). The fabrication of nurse-patient relationships. *Social Science and Medicine*, 17(8), 457-460.
- Arnold, E. (1995). Structuring the relationship. In E. Arnold & K. U. Boggs (Eds.), *Interpersonal Relationships, Professional communication skills for nurses* (2nd ed., pp. 292-304). Philadelphia: W.B.Saunders Company.
- Ashworth, P., & Morrison, P. (1991). Problems of competence-based nurse education. *Nurse Education Today*, 11(4), 256-260. doi: 10.1016/0260-6917(91)90087-q

- Åstedt-Kurki, P., Isola, A., Tammentie, T., & Kervinen, U. (2001). Importance of humour to client-nurse relationships and clients' well-being. *International Journal of Nursing Practice*, 7(2), 119-125.
- Astedt-Kurki, P., & Liukkonen, A. (1994). Humour in nursing care. *Journal of Advanced Nursing*, 20(1), 183-188.
- Atkinson, K., Jackson, C., & Rawlin, M. (2007). Competence and the quality framework. *Australian Family Physician*, 36(1-2), 24-26.
- Attree, M. (2001). Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *Journal of Advanced Nursing*, 33(4), 456-466.
Retrieved from doi:10.1046/j.1365-2648.2001.01689.x
- Australian Bureau of Statistics. (2010). Western Australian Statistical Indicators, 2010.
<http://www.abs.gov.au/ausstats/abs@.nsf/Products/887E148C8E0783BBCA25781D000D6902>
- Australian Education Council and Ministers for Vocational Education, Employment and Training. (1992). *Putting general education to work: The key competencies report*. Australian Education Council and Ministers for Vocational Education, Employment and Training.
- Australian Government.(2009). *People Capability Framework*. Department of Defence Intelligence, Security and International Policy. Canberra.
- Australian Institute of Health and Welfare. (2010). Nursing and midwifery labour force 2008. *Bulletin no. 81*. Canberra: Australian Institute of Health and Welfare.
- Australian Nursing & Midwifery Council. (2005). *National Competency Standard for the Registered Nurse*. Canberra, ACT: Australian Nursing & Midwifery Council, Inc
- Australian Nursing & Midwifery Council. (2006). *Competency Standards for the Registered Nurse* (4th ed.). Canberra, ACT: Australian Nursing & Midwifery Council, Inc.
- Australian Nursing & Midwifery Council. (2008a). *Code of Ethics for Nurses in Australia*. Canberra: Australian Nursing and Midwifery Council, Inc.
- Australian Nursing & Midwifery Council. (2008b). *Code of Professional Conduct for Nurses in Australia*. Canberra, ACT: Australian Nursing & Midwifery Council, Inc
- Australian Nursing & Midwifery Council. (2009). *ANMC Continuing Competence Framework for the Registered Nurse*. Canberra, ACT: Australian Nursing & Midwifery Council, Inc.

- Barnett, R. (1997). Beyond competence. In F. Coffield & B. Williamson (Eds.), *Repositioning Higher Education*. Buckingham: Society for Research into Higher Education and Open University Press.
- Barratt-Pugh. (1995). *The competence approach: Constricting development or the freedom to learn?* Paper presented at the A Focus on Learning, 4th Annual Teaching Learning Forum, Perth: Edith Cowan University.
- Benner, P. (1982). Issues in competency-based testing. *Nursing Outlook*, 30(5), 303-309.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Manlo Park: Addison-Wesley Publishing.
- Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying, health, illness, and caring. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health care*. (pp. 99-128). London: Sage.
- Benner, P., Tanner, C. A., & Chesla, C. A. (1996). *Expertise in nursing practice: caring, clinical judgement, and ethics*. New York: Springer Publishing Company, Inc.
- Benner, P., Tanner, C. A., & Chesla, C. A. (1997). Becoming an expert nurse. *The American Journal of Nursing*, 97(6), 16BBB-16DDD.
- Benner, P., & Wrubel, J. (1989). *The Primacy of Caring*. Menlo Park: Addison-Wesley.
- Binnie, A. & Titchen, A. (1999). *Freedom to Practice: The Development of Patient Centred Nursing*. Oxford: Butterworth Heinemann.
- Biro, M. A., Waldenstrom, U., Brown, S., & Pannifex, J. H. (2003). Satisfaction with team midwifery care for low- and high-risk women: A randomized controlled trial. *Birth: Issues in Perinatal Care*, 30(1), 1-10.
- Björkström, M. E., Johansson, I. S., & Athlin, E. E. (2006). Is the humanistic view of the nurse role still alive – in spite of an academic education? *Journal of Advanced Nursing*, 54(4), 502-510. doi: 10.1111/j.1365-2648.2006.03845.x
- Blockley, C. (1994). Intimate caring. *Nursing New Zealand*, 2(2), 28.
- Bonner, A. (2007). Focusing on patients: Differences between the practice of expert and non-expert nephrology nurses. *Renal Society of Australasia Journal*, 3(1), 5-12.
- Bonner, A., & Greenwood, J. (2006). The acquisition and exercise of nephrology nursing expertise: A grounded theory study. *Journal of Clinical Nursing*, 15(4), 480-489.

- Booth, J., & Waters, K. R. (1995). The multifaceted role of the nurse in the day hospital. *Journal of Advanced Nursing*, 22(4), 700-706. doi: DOI: 10.1046/j.1365-2648.1995.22040700.x
- Bowden, J., & Masters, G. (1993). *Implications for higher education of a competency-based approach to education and training*. Canberra: Department of Employment, Education and Training.
- Boyatzis, R. E. (1982). *The competent manager: A model for effective performance*. New York: John Wiley & Sons.
- Bradshaw, A. (1997). Defining 'competency' in nursing (Part I): A policy review. *Journal of Clinical Nursing*, 6(5), 347-354. doi: 10.1111/j.1365-2702.1997.tb00327.x
- Bradshaw, A. (1998). Defining 'competency' in nursing (part II): An analytical review. *Journal of Clinical Nursing*, 7(2), 103-111. doi: 10.1046/j.1365-2702.1998.00130.x
- Bradshaw, A. (2000a). Competence and British nursing: A view from history. *Journal of Clinical Nursing*, 9(3), 321-329.
- Bradshaw, A. (2000b). Editorial... competence in the practicalities of caring for patients. *Journal of Clinical Nursing*, 9(3), 319-320.
- Bradshaw, A., & Merriman, C. (2008). Nursing competence 10 years on: Fit for practice and purpose yet? *Journal of Clinical Nursing*, 17(10), 1263-1269.
- Brown, C. (2003). Adaptation in action: The NHS modernisation agency's critical care programme. In D. Kernick (Ed.), *Complexity and Healthcare Organization*. Oxon UK: Radcliffe Medical press.
- Brykczynski, K. A. (1998). Clinical exemplars describing expert staff nursing practices. *Journal of Nursing Management*, 6(6), 351-359. doi: 10.1046/j.1365-2834.1998.00088.x
- Bullock, A., & Trombley, S. (Eds.). (1999) *The New Fontana Dictionary of Modern Thought*. (3rd ed.). London: Harper-Collins.
- Callen, B. L., Mahoney, J. E., Grieves, C. B., Wells, T. J., & Enloe, M. (2004). Frequency of hallway ambulation by hospitalized older adults on medical units of an academic hospital. *Geriatric Nursing*, 25(4), 212-217.
- Carville, C. (2003). *The evolution and experience of stomal therapy nurses in Australia 1995-2000*. PhD, Edith Cowan University, Perth.
- Chaffee, M. W., & McNeill, M. M. (2007). A model of nursing as a complex adaptive system. *Nursing Outlook*, 55(5), 232-241.e233. doi: 10.1016/j.outlook.2007.04.0031

- Chang, E., & Hancock, K. (2003). Role stress and role ambiguity in new nursing graduates in Australia. *Nursing & Health Sciences*, 5(2), 155-163.
- Chang, E. M., Daly, J. W., Hancock, K. M., Bidewell, J., Johnson, A., Lambert, V. A., et al. (2006). The relationships among workplace stressors, coping methods, demographic characteristics, and health in Australian nurses. *Journal of Professional Nursing*, 22(1), 30-38.
- Chapman, H. (1999). Some important limitations of competency-based education with respect to nurse education: an Australian perspective. *Nurse Education Today*, 19(2), 129-135.
- Chiarella, M., Thoms, D., Lau, C., & McInnes, E. (2008). An overview of the competency movement in nursing and midwifery. *Collegian*, 15, 45-53.
- Christopher, K. A., & Hegedus, K. (2000). Oncology patients' and oncology nurses' perceptions of nurse caring behaviours. *European Journal of Oncology Nursing*, 4(4), 196-204.
- Coe, R., & Gould, D. (2008). Disagreement and aggression in the operating theatre. *Journal of Advanced Nursing*, 61(6), 609-618.
- Coleman, V. I., & Borman, W. C. (2000). Investigating the underlying structure of the citizenship performance domain. *Human Resource Management Review*, 10(1), 25-44. doi: 10.1016/s1053-4822(99)00037-6
- Coulon, L., Mok, M., Krause, K., & Anderson, M. (1996). The pursuit of excellence in nursing care: what does it mean? *Journal of Advanced Nursing*. 24(4), 817-826.
- Cowan, D. T., Norman, I., & Coopamah, V. P. (2005). Competence in nursing practice: A controversial concept - A focused review of literature. *Nurse Education Today*, 25(5), 355-362. doi: 10.1016/j.nedt.2005.03.002
- Crilly, J., Chaboyer, W., & Creedy, D. (2004). Violence towards emergency department nurses by patients. *Accident and Emergency Nursing*, 12(2), 67-73.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage.
- Crowden, A. (1994). On the moral nature of nursing practice. *Journal of Advanced Nursing*, 20, 1104-1110.
- Davis, A., Hershberger, J., Ghan, L. C., & Lin, J. Y. (1990). The good nurse: descriptions from the People's Republic of China. *Journal of Advanced Nursing*, 15(7), 829-834. doi: 10.1111/j.1365-2648.1990.tb01914.x
- DeKeyser, F. G., Wruble, A. W., & Margalith, I. (2003). Patients voice issues of dress and address. *Holistic Nursing Practice*, 17(6), 290-294.

- del Bueno, D. (2005). A crisis in critical thinking. *Nursing Education Perspectives*, 26(5), 278-282. doi: 10.1043/1536-5026(2005)026[0278:ACICT]2.0.CO;2
- Denzin, N., & Lincoln, Y. (Eds.). (1994). *Handbook of qualitative research*. Thousand Oaks: Sage Publications.
- Denzin, N. K. (1989). *Interpretive Interactionism*. Newbury Park: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.
- DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, 22(3), 351-372. doi: 10.1177/019394590002200308
- Dolan, G. (2003). Assessing student nurse clinical competency: Will we ever get it right? *Journal of Clinical Nursing*, 12(1), 132-141. doi: 10.1046/j.1365-2702.2003.00665.x
- Dreyfus, H., & Dreyfus, S. (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York: The Free Press.
- Drury, J., Bailey, M., Blackmore, A. M., & Maltby, H. J. (2003). The Gregor Effect: impediments to providing care by nurses and significant others who experience a negative reaction to the patient's condition. *Asian Journal of Nursing Studies*, 6(3), 21-28.
- Emden, C., & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice*, 4(4), 206-212.
- Eraut, M. (1998). Concepts of competence. *Journal of Interprofessional Care*, 12(2), 127-139.
- Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. London: Routledge.
- Fabricius, J. (1991). Running on the spot or can nursing really change. *Psychoanalytic Psychotherapy*, 5(2), 97-108. doi: 10.1080/02668739100700151
- Fagermoen, M. S. (1997). Professional identity: Values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, 25(3), 434-441.
- Fagerstrom, L. (2006). The dialectic tension between 'being' and 'not being' a good nurse. *Nursing Ethics*, 13(6), 622-632.
- Farrell, G. A. (1999). Aggression in clinical settings: nurses' views — a follow-up study. *Journal of Advanced Nursing*, 29(3), 532-541. doi: 10.1046/j.1365-2648.1999.00920.x

- Farrell, G. A., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: Findings from an Australian study. *Journal of Advanced Nursing*, 55(6), 778-787. doi: 0.1111/j.1365-2648.2006.03956.x
- Fealy, G. M. (2004). 'The good nurse': Visions and values in images of the nurse. *Journal of Advanced Nursing*, 46(6), 649-656.
- Finlay, L. (2003). The reflexive journey: Mapping multiple routes. In L. Findlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences* (pp. 3-20). Oxford: Blackwell Science Ltd.
- Finfgeld-Connett, D. (2008). Meta-synthesis of caring in nursing. *Journal of Clinical Nursing*, 17(2), 196-204. doi: 10.1111/j.1365-2702.2006.01824.x
- Finlayson, J. G. (2005). *Habermas: A very short introduction*. Oxford: Oxford University Press.
- Fontana, A., & Frey, J. H. (2005). The interview: From neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 695-728). Thousand Oaks: Sage Publications.
- Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. *Journal of Advanced Nursing*, 20(6), 1085-1093.
- Fraser, S. W., & Greenhalgh, T. (2001). Complexity science: Coping with complexity: Educating for capability. *British Medical Journal*, 323(7316), 799-803.
- Freeman, M., Miller, C., & Ross, N. (2000). The impact of individual philosophies of teamwork on multi-professional practice and the implications for education. *Journal of Interprofessional Care*, 14(3), 237-247. doi: 10.1080/jic.14.3.237.247
- Friedman, W. (1971). Changes in diploma nursing students' perceptions of a good nurse. *Nursing Forum*, 10(1), 72-79.
- Gardner, A., Hase, S., Gardner, G., Dunn, S. V., & Carryer, J. (2008). From competence to capability: A study of nurse practitioners in clinical practice. *Journal of Clinical Nursing*, 17(2), 250-258. doi: 10.1111/j.1365-2702.2006.01880.x
- Gardner, G., Carryer, J., Gardner, A., & Dunn, S. (2006). Nurse Practitioner competency standards: Findings from collaborative Australian and New Zealand research. *International Journal of Nursing Studies*, 43(5), 601-610.
- Giro, E. A. (1993). Assessment of competence in clinical practice -- a review of the literature. *Nurse Education Today*, 13(2), 83-90. doi: 10.1016/0260-6917(93)90023-u

- Giro, E. A. (2000). Assessment of graduates and diplomates in practice in the UK - are we measuring the same level of competence? *Journal of Clinical Nursing*, 9(3), 330-337.
- Goldsmith, S. (1999). Beyond competencies in Australian nursing. *The Australian Electronic Journal of Nursing Education*, 5(1). Retrieved from http://www.scu.edu.au/schools/nhcp/aejne/archive/vol5-1/goldsmithvol5_1.html
- Gonczi, A. (1994). Competency based assessment in the professions in Australia. *Assessment in Education*, 1(1), 27-44.
- Gonczi, A., Hager, P., & Oliver, L. (1990). Establishing competency-based standards in the professions. *Series Research Paper1 :National Office for Overseas Skill Recognition* (Ed.). Canberra: Australia Government Publishing Service.
- Graham, I., Partlow, C., & Maxwell, E. (2004). What makes a good nurse?: A study conducted for WDGH NHS Trust by Bournemouth University to identify nursing practice and care within the Trust: Bournemouth University, Institute of Health & Community Studies, Poole.
- Graves, C. W. (1970). Levels of existence: An open system of values. *Journal of Humanistic Psychology*, 10, 131-155.
- Graves, C. W. (1974). Human nature prepares for a momentous leap. *The Futurist*, April, 72-87.
- Greenslade, J. H., & Jimmieson, N. L. (2007). Distinguishing between task and contextual performance for nurses: Development of a job performance scale. *Journal of Advanced Nursing*, 58(6), 602-611.
- Guba, E. G. (1990). *The paradigm dialogue*. Newbury Park: Sage.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco: Jossey-Bass Publishers.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park: Sage Publications.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks: Sage Publications.
- Hahn, S., Kroenke, K., Spitzer, R., Brody, D., Williams, J., Linzer, M., et al. (1996). The difficult patient. *Journal of General Internal Medicine*, 11(1), 1-8. doi: 10.1007/bf02603477

- Halldorsdottir, S., & Hamrin, E. (1997). Caring and uncaring encounters within nursing and health care from the cancer patient's perspective. *Cancer Nursing*, 20(2), 120-128.
- Hase, S. (2000). Measuring organisational capability: Beyond competence. Lismore: Southern Cross University.
- Hase, S. (2002). *Simplicity in complexity:capable people and capable organisations need each other*. Paper presented at the Vocational Education and Training Association Conference, Melbourne.
- Hase, S., & Davis, L. (1999a). *From competence to capability: the implications for human resource development and management*. Paper presented at the Millenium challenges in management, education, cybertechnology, and leadership: Association of International Management, 17th Annual Conference, San Diego.
- Hase, S., & Davis, L. (1999b). From competence to capability: the implications for human resource development and management. *Graduate College of Management Papers*. Retrieved from http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1126&context=gcm_public&sei-redir=1#search=%22davis%20Hase%201999%22
- Hase, S., & Kenyon, C. (2000). *From andragogy to heutagogy*. Royal Melbourne Institute of Technology. http://www.avetra.org.au/abstracts_and_papers_2001/Hase-Kenyon_full.pdf
- Hase, S., & Tay, B. H. (2004). Capability for complex systems: Beyond competence. *Graduate College of Management Papers*. Retrieved from http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1122&context=gcm_public&sei-redir=1#search=%22Hase%20Tay%202004%22
- Healy, C. M., & McKay, M. F. (2000). Nursing stress: The effects of coping strategies and job satisfaction in a sample of Australian nurses. *Journal of Advanced Nursing*, 31(3), 681-688.
- Hearn, G., Close, A., Smith, B., & Southey, G. (1996). Defining generic professional competencies in Australia: Towards a framework for professional development. *Asia Pacific Journal of Human Resources*, 34(1), 44-62. doi: 10.1177/103841119603400103
- Hemsley-Brown, J., & Foskett, N. H. (1999). Career desirability: Young people's perceptions of nursing as a career. *Journal of Advanced Nursing*, 29(6), 1342-1350. doi: 10.1046/j.1365-2648.1999.01020.x
- Henderson, V. (1964). The nature of nursing. *The American Journal of Nursing*, 64(8), 62-68.
- Henderson, V. (2006). The concept of nursing*. *Journal of Advanced Nursing*, 53(1), 21-31. doi: 10.1111/j.1365-2648.2006.03660.x

- Hertz, R. (Ed.). (1997). *Reflexivity and voice*. Thousand Oaks: Sage Publications.
- Heywood, L., Gonczi, A., & Hager, P. (1992). A guide to development of competency standards for professions *Series Research Paper 7: National Office of Overseas Skills Recognition*. (Ed.). Canberra : Australian Government Publication Service.
- Higgs, J. (2001). Charting standpoints in qualitative research. In H. Byrne-Armstrong, J. Higgs & D. Horsfall (Eds.), *Critical Moments in Qualitative Research* (pp. 44-67). Oxford: Butterworth-Heinmann.
- Higgs, J., & Titchen, A. (1995). The nature, generation and verification of knowledge. *Physiotherapy*, 81(9), 521-530. doi: 10.1016/s0031-9406(05)66683-7
- Higgs, J., & Titchen, A. (1998). Research and knowledge. *Physiotherapy*, 84(2), 72-80. doi: 10.1016/s0031-9406(05)66543-1
- Holloway, I., & Wheeler, S. (1996). *Qualitative research for nurses*. Oxford: Blackwell Science.
- Hutton, S., & Gates, D. (2008). Workplace incivility and productivity losses among direct care staff. *AAOHN Journal*, 56(4), 168-175.
- Izumi, S., Konishi, E., Yahiro, M., & Kodama, M. (2006). Japanese patients' descriptions of "The Good Nurse": Personal involvement and professionalism. *Advances in Nursing Science Philosophy and Ethics*, 29(2), E14-E26.
- Jasper, M. A. (1994). Expert: A discussion of the implications of the concept as used in nursing. *Journal of Advanced Nursing*, 20(4), 769-776.
- Jenks, J. M. (1993). The pattern of personal knowing in nurse clinical decision making. *Journal of Nursing Education*, 32(9), 399-405.
- Jensen, K. P., Back-Pettersson, S., & Segesten, K. (1996). "Catching my wavelength": perceptions of the excellent nurse. *Nursing Science Quarterly*, 9(3), 115-120. doi: 10.1177/089431849600900310
- Johnson, M., & Webb, C. (1995). The power of social judgement: struggle and negotiation in the nursing process. *Nurse Education Today*, 15(2), 83-89. doi: 10.1016/s0260-6917(95)80024-7
- Kahn, D. L., & Stevens, R. H. (1988). Caring and practice: Construction of the nurse's world. *Scholarly Inquiry for Nursing Practice: An International Journal*, 2(3), 201-216.

- Kalisch, B. J. (2009). Nurse and nurse assistant perceptions of missed nursing care: what does it tell us about teamwork? *Journal of Nursing Administration*, 39(11), 485-493. doi: 10.1097/NNA.0b013e3181bd61ac
- Kalisch, B. J., Landstrom, G., & Williams, R. A. (2009). Missed nursing care: errors of omission. *Nursing Outlook*, 57(1), 3-9. doi: 10.1016/j.outlook.2008.05.007
- Kalisch, B. J., Landstrom, G. L., & Hinshaw, A. S. (2009). Missed nursing care: A concept analysis. *Journal of Advanced Nursing*, 65(7), 1509-1517. doi: 10.1111/j.1365-2648.2009.05027.x
- Kalisch, B. J., & Williams, R. A. (2009). Development and psychometric testing of a tool to measure missed nursing care. *Journal of Nursing Administration*, 39(5), 211-219. doi: 10.1097/NNA.0b013e3181a23cf5
- Kangas, S., Kee, C. C., & McKee-Waddle, R. (1999). Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care. *Journal of Nursing Administration*, 29(1), 32-42.
- Kelly, G. A. (1955). *The Psychology of personal constructs* (Vol. One: A Theory of Personality). New York: Norton.
- Kendall, S. (1999). Identifying outstanding clinical nurses: The 'star' shines in oncology. *Nursing & Health Sciences*, 1(2), 113-123.
- Kidder, D. L. (2002). The influence of gender on the performance of organizational citizenship behaviors. *Journal of Management*, 28(5), 629-648. doi: 10.1177/014920630202800504
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Thousand Oaks: Sage Publication Inc.
- Klemp, G. O., & McClelland, D. C. (1986). What characterises intelligent functioning among senior managers? In R. J. Sternberg & R. K. Wagner (Eds.), *Practical Intelligence: Nature and Origins of Competence in the Everyday World* (pp. 31-50). New York: Cambridge University Press.
- Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21(5), 827-836.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing*, 24(1), 174-184.
- Koekkoek, B., Hutschemaekers, G., van Meijel, B., & Schene, A. (2011). How do patients come to be seen as 'difficult'? A mixed-methods study in community mental health care. *Social Science & Medicine*, 72(4), 504-512. doi: 10.1016/j.socscimed.2010.11.036

- Kralik, D., Koch, T., & Wotton, K. (1997). Engagement and detachment: Understanding patients' experiences with nursing. *Journal of Advanced Nursing*, 26(2), 399-407.
- Kuhn, T. S. (1996). *The structure of scientific revolutions* (3rd ed.). Chicago: University of Chicago Press
- Larson, P.J. (1984). Important nurse caring behaviours perceived by patients with cancer. *Oncology Nursing Forum*, 11(6), 46-50.
- Larsson, G., Peterson, V. W., Lampic, C., Essen, L. v., & Sjöden, P. (1998). Cancer patient and staff ratings of the importance of caring behaviours and their relations to patient anxiety and depression. *Journal of Advanced Nursing*, 27(4), 855-864.
- Lea, A., & Watson, R. (1996). Caring research and concepts: a selected review of the literature. *Journal of Clinical Nursing*, 5(2), 71-77. doi: 10.1111/j.1365-2702.1996.tb00230.x
- Lee, J. L., Chang, B. L., Pearson, M. L., Kahn, K. L., & Rubenstein, L. V. (1999). Does what nurses do affect clinical outcomes for hospitalized patients? A literature review. *Health Services Research*, 34(5 Part 1), 1011-1032.
- Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. . In J. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 95-115). Thousand Oaks, CA: Sage.
- Leininger, M. M. (Ed.). (1984). *Care: The essence of nursing and health*. New York: Slack.
- Lewis, B. R. (1980). Personality profiles for qualified nurses: Possible implications for recruitment and selection of trainee nurses. *International Journal of Nursing Studies*, 17(4), 221-234.
- Lewis, B. R., & Cooper, C. I. (1976). Personality measurement among nurses: a review. *International Journal of Nursing Studies*, 13(4), 209-229.
- Lewis, S. L., Bonner, P. N., Campbell, M. A., Cooper, C. L., & Willard, A. (1994). Personality, stress, coping, and sense of coherence among nephrology nurses in dialysis settings. *American Nephrology Nurses Association Journal*, 21(6), 325-335.
- Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, 1(3), 275.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.

- Lindley, P., O'Halloran, P., & Juriansz, D. (2001). Capable Practitioner: A framework and list of the practitioner capabilities required to implement The National Service Framework for Mental Health. London: The Sainsbury Centre for Mental Health.
- Lok, P., & Crawford, J. (2001). Antecedents of organizational commitment and the mediating role of job satisfaction. *Journal of Managerial Psychology*, 16(7/8), 594-594-613.
- Lok, P., Westwood, R., & Crawford, J. (2005). Perceptions of organisational subculture and their significance for organisational commitment. *Applied Psychology*, 54(4), 490-514. doi: 10.1111/j.1464-0597.2005.00222.x
- MacDonald, M. (2003). Seeing the cage: stigma and its potential to inform the concept of the difficult patient. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, 17(6), 305-312.
- Mallett, J., & A'Hern, R. (1996). Comparative distribution and use of humour within nurse--patient communication. *International Journal of Nursing Studies*, 33(5), 530-550.
- March, P. L., & McPherson, A. (1996). The important attributes of a nurse from the perspective of qualified and student nurses. *Journal of Advanced Nursing*, 24(4), 810-816. doi: 10.1046/j.1365-2648.1996.25820.x
- Marck, P. (1990). Therapeutic reciprocity: A caring phenomenon. *Advances in Nursing Science*, 13(1), 49-59.
- Masters, G. M., & McCurry, D. (1990). Competency-Based assessment in the professions. *Series Research Papers. National Office of Overseas Skills Recognition*. (Ed.). Canberra: Australian Government Publishing Service.
- Matlow, A. G., Wright, J. G., Zimmerman, B., Thomson, K., & Valente, M. (2006). How can the principles of complexity science be applied to improve the coordination of care for complex pediatric patients? *Quality and Safety in Health Care*, 15(2), 85-88. doi: 10.1136/qshc.2005.014605
- Mayer, E. (1992). Key competencies: report of the Committee to advise the Australian Education Council and Ministers of Vocational Education, Employment and Training on employment-related key competencies for postcompulsory education and training [Mayer report]. Canberra: Australian Education Council and Ministers of Vocational Education, Employment and Training.
- Mayer, M. L. (2008). On being a 'difficult' patient. *Health Affairs*, 27(5), 1416-1421.
- Mays, N., & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *British Medical Journal*, 311(6997), 109-112.

- McAllister, J. (1998). Competency standards:clarifying the issues. *Contemporary Nurse*, 7(3), 131-137.
- McCabe, C. (2004). Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing*, 13(1), 41-49. doi: 10.1111/j.1365-2702.2004.00817.x
- McCance, T. V., McKenna, H. P., & Boore, J. R. P. (1997). Caring: dealing with a difficult concept. *International Journal of Nursing Studies*, 34(4), 241-248. doi: 10.1016/s0020-7489(97)00011-4
- McCance, T. V., McKenna, H. P., & Boore, J. R. P. (1999). Caring: theoretical perspectives of relevance to nursing. *Journal of Advanced Nursing*, 30(6), 1388-1395.
- McColl, E., Thomas, L., & Bond, S. (1996). A study to determine patient satisfaction with nursing care. *Nursing Standard*, 10(52), 34-38.
- McCormack, B. (2003). Researching nursing practice: does person-centredness matter? *Nursing Philosophy*, 4(3), 179-188.
- McGaghie, W. C. (1991). Professional competence evaluation. *Educational Researcher*, 20(1), 3-9.
- McMillan, M., Andrews, J., & Bujack, E. (1996). A question of advanced competence. *Australian Nursing Journal*, 4(3), 30-31.
- McMullan, M., Endacott, R., Gray, M. A., Jasper, M., Miller, C. M. L., Scholes, J., et al. (2003). Portfolios and assessment of competence: a review of the literature. *Journal of Advanced Nursing*, 41(3), 283-294. doi:10.1046/j.1365-2648.2003.02528.x
- McMurray, A., Chaboyer, W., Wallis, M., & Fetherston, C. (2010). Implementing bedside handover: Strategies for change management. *Journal of Clinical Nursing*, 19(17/18), 2580-2589.
- McWilliam, C. L., & Wong, C. A. (1994). Keeping it secret: The costs and benefits of nursing's hidden work in discharging patients. *Journal of Advanced Nursing*, 19(1), 152-163. doi: 10.1111/j.1365-2648.1994.tb01063.x
- Meerabeau, L. (1992). Tacit nursing knowledge: An untapped resource or a methodological headache?*. *Journal of Advanced Nursing*, 17(1), 108-112. doi: 10.1111/j.1365-2648.1992.tb01825.x
- Meleis, A. I. (2005). *Theoretical nursing: Development and progress* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Merriam-Webster Dictionary On-line (2000).

- Messick, S. (1984). The psychology of educational measurement. *Journal of Educational Measurement*, 21(3), 215-237.
- Michel, J. S., Mitchelson, J. K., Pichler, S., & Cullen, K. L. (2009). Clarifying relationships among work and family social support, stressors, and work-family conflict. *Journal of Vocational Behavior*, 76(1), 91-104.
- Miles, M. B., & Huberman, A. M. (1999). *Qualitative data analysis*. Thousand Oaks: Sage Publications.
- Milligan, F. (1998). Defining and assessing competence: The distraction of outcomes and the importance of educational process. *Nurse Education Today*, 18(4), 273-280.
- Minichiello, V., Madison, J., Hays, T., & Parmenter, G. (2004). Doing qualitative research. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook of Research Methods for Nursing and Health Science* (2nd ed., pp. 412-446). Frenchs Forest: Pearson Education Australia.
- Morrison, P. (1990). An example of the use of repertory grid technique in assessing nurses' self-perceptions of caring. *Nurse Education Today*, 10(4), 253-259. doi: 10.1016/0260-6917(90)90048-u
- Morrison, P. (1991). The caring attitude in nursing practice: A repertory grid study of trained nurses' perceptions. *Nurse Education Today*, 11(1), 3-12. doi: 10.1016/0260-6917(91)90118-t
- Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research*, 40(1), 120-123.
- Morse, J. M., Bottorff, J., Anderson, G., O'Brien, B., & Solberg, S. (2006). Beyond empathy: Expanding expressions of caring. *Journal of Advanced Nursing*, 53(1), 75-87.
- Morse, J., Bottorff, J., Neander, W., & Solberg, S. (1991). Comparative analysis of conceptualizations and theories of caring. *IMAGE: Journal of Nursing Scholarship*, 23, 119-126.
- Morse, J. M., & Singleton, J. (2001). Exploring the technical aspects of "Fit" in qualitative research. *Qualitative Health Research*, 11(6), 841-847. doi: 10.1177/104973201129119424
- Morse, J. M., Solberg, S. M., Neander, W. L., Bottorff, J. L., & Johnson, J. L. (1990). Concepts of caring and caring as a concept. *Advances in Nursing Science*, 13(1), 1-14.
- Mustard, L. W. (2002). Caring and competency. *JONA's Healthcare Law, Ethics, and Regulation*, 4(2), 36-43.

- Nagelsmith, L. (1995). Competence: An evolving concept. *Journal of Continuing Education in Nursing*, 26(6), 245-248.
- Nelson, S., & McGillion, M. (2004). Expertise or performance? Questioning the rhetoric of contemporary narrative use in nursing. *Journal of Advanced Nursing*, 47(6), 631-638.
- Nelson, S., & Purkis, M. E. (2004). Mandatory reflection: The Canadian reconstitution of the competent nurse. *Nursing Inquiry*, 11(4), 247-257.
- Nightingale, F. (1860). *Notes on Nursing: What It Is, and What It Is Not*. New York: D. Appleton and Company.
- Noble-Adams, R. (2001). "Exemplary" nurses -- an exploration of the phenomenon. *Nursing Praxis in New Zealand*, 17(1), 24-33.
- International Council of Nurses. (2004). The Global shortage of registered nurses: an overview of issues and actions. Geneva: International Council of Nurses.
- O'Berle, K., & Davies, B. (1992). Support and caring: Exploring the concepts. *Oncology Nursing Forum*, 19(5), 763-767.
- O'Connell, B., Young, J., Brooks, J., Hutchings, J., & Lofthouse, J. (2000). Nurses' perceptions of the nature and frequency of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing*, 9(4), 602-610.
- Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Profession and society. Ethics in qualitative research. *Journal of Nursing Scholarship*, 33(1), 93-96.
- Oxford English Dictionary. (1989.) (2nd ed.). Oxford: Oxford University Press.
- Palladino Schultheiss, D. E. (2006). The interface of work and family life. *Professional Psychology: Research and Practice* Retrieved 4, 37, from <http://www.sciencedirect.com/science/article/B6X00-4KN5JKP-2/2/cd0f5e8821095f2680bb09192cd84d91>
- Parse, R. R. (1987). *Nursing science: Major paradigms, theories and critiques*. Philadelphia: W. B. Saunders.
- Parse, R. R. (1985). *Illuminations: The human becoming theory in practice and research*. New York: National League of Nursing.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluationmMethods* (3rd ed.). London: Sage.
- Pearson, A., FitzGerald, M., & Walsh, K. (2002). Nurses' views on competency indicators for Australian nursing. *Collegian*, 9(1), 36-40.

- Pearson, A., Fitzgerald, M., Walsh, K., & Borbasi, S. (2002). Continuing competence and the regulation of nursing practice. *Journal of Nursing Management*, 10(6), 357-364. doi: 10.1046/j.1365-2834.2002.00339.x
- Perry, B. (2009). Being an exemplary role model: It begins with an optimistic attitude. *Journal for Nurses in Staff Development*, 25(5), 242-248.
- Pfetscher, S. A. (2006). Florence Nightingale: Modern nursing. In A. M. Tomey & M. R. Alligood (Eds.), *Nursing Theorists and Their Work* (pp. 71-90). St Louis: Mosby Elsevier.
- Piercey, C. (1995). *Assessing Clinical Competencies*. Paper presented at the Proceedings of the 4th Annual Teaching and Learning Forum, Perth: Edith Cowan University. <http://cea.curtin.edu.au/tlf/tlf1995/piercey.html>
- Pinikahana, J., & Happell, B. (2004). Stress, burnout and job satisfaction in rural psychiatric nurses: A Victorian study. *Australian Journal of Rural Health*, 12(3), 120-125.
- Plsek, P. E., & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *British Medical Journal*, 323(7313), 625-628.
- Polgar, S., & Thomas, S. (2000). *Introduction to research in the health sciences* (4th ed.). Edinburgh: Churchill Livingstone.
- Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8(3), 341.
- Purkis, M. E., & Nelson, S. (2005). Nursing competence: Constructing persons and a form of life. In M. McIntyre, E. Thomlinson & C. McDonald (Eds.), *Realities of Canadian Nursing: Professional, Practice and Power Issues* (2nd ed., pp. 227-240). Philadelphia: LippincottWilliams & Wilkins.
- Rasmussen, H. H., Kondrup, J., Staun, M., Ladefoged, K., Kristensen, H., & Wengler, A. (2004). Prevalence of patients at nutritional risk in Danish hospitals. *Clinical Nutrition*, 23(5), 1009-1015. doi: 10.1016/j.clnu.2004.01.001
- Rchaidia, L., Dierckx de Casterle, B., De Blaeser, L., & Gastmans, C. (2009). Cancer patients' perceptions of the good nurse: A literature review. *Nursing Ethics*, 16(5), 528-542.
- National Office of Overseas Skills Recognition. (1995). *Research Series Paper No. 9. The Implications of the Implementation of National Competency Standards in the Professions: Final Report*. Canberra: National Office of Overseas Skills Recognition.

- Redfern, S., Norman, I., Calman, L., Watson, R., & Murrells, T. (2002). Assessing competence to practice in nursing: A review of the literature. *Research Papers in Education* 17(1), 55-71.
- Roberts, K., & Taylor, B. (1998). *Nursing research processes: An Australian perspective*. Melbourne: International Thompson Publishing Company.
- Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, 20(12), 600-607.
- Roche, M., Diers, D., Duffield, C., & Catling-Paul, C. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13-22. doi: 10.1111/j.1547-5069.2009.01321.x
- Rodney, V. (2000). Nurse stress associated with aggression in people with dementia: its relationship to hardiness, cognitive appraisal and coping. *Journal of Advanced Nursing*, 31(1), 172-180.
- Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin Company.
- Rokeach, M. (1973). *The nature of human values*. New York: Free Press.
- Rosenstein, A., & O'Daniel, M. (2008). Survey of the impact of disruptive behaviours and communication defects on patient safety. *The Joint Commission Journal on Quality and Patient Safety*, 34(8), 464-471.
- Rush, B., & Cook, J. (2006). What makes a good nurse? Views of patients and carers. *British Journal of Nursing (BJN)*, 15(7), 382-385.
- Sand, A. (2003). Nurses' personalities, nursing-related qualities and work satisfaction: A 10 year perspective. *Journal of Clinical Nursing*, 12(2), 177-187. doi: 10.1046/j.1365-2702.2003.00729.x
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Research*, 8(3), 27-37.
- Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Santy, J., & Mackintosh, C. (2000). Assessment and learning in post-registration nurse education. *Nursing Standard*, 14(18), 38-38-41.
- Schneider, Z., Whitehead, D., Elliott, D., Lobiondo-Wood, G., & Haber, J. (2007). *Nursing & midwifery research: Methods and appraisal for evidence-based practice* (3rd ed.). Marrickville: Elsevier Australia.
- Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*. San Francisco, CA: Jossey-Bass.

- Searle, C. (2001). Qualitative methods: Validity and reliability. *European Journal of Cancer Care*, 10(2), 133-134.
- Sen, A. (1993). Capability and well being. In Nussbaum & Sen (Eds.), *The Quality of Life*. Oxford: Clarendon Press.
- Sharp, K., Wilcock, S., Sharp, D., & MacDonald, H. (1995). Assessing competence to practice in nursing: A review of the literature. *Research Papers in Education* 17(1), 51-77.
- Sidani, S., Epstein, D., & Miranda, J. (2006). Eliciting patient treatment preferences: A strategy to integrate evidence-based and patient-centered care. *Worldviews on Evidence-Based Nursing*, 3(3), 116-123.
- Silverman, M., Ricci, E. M., & Gunter, M. J. (1990). Strategies for increasing the rigor of qualitative methods in evaluation of health care programs. *Evaluation Review*, 14(1), 57.
- Smith, K. V., & Godfrey, N. S. (2002). Being a good nurse and doing the right thing: A qualitative study. *Nursing Ethics*, 9(3), 301-312. doi: 10.1191/0969733002ne512oa
- Spencer, L. M., & Spencer, S. M. (1993). *Competence at work: Models for superior performance*. New York: Wiley.
- Spradley, J. P. (1978). *The ethnographic interview*. New York: Holt, Rhinehart and Wnston.
- Stanley, D. (2006). In command of care: Toward the theory of congruent leadership. *Journal of Research in Nursing*, 11(2), 132-144. doi: 10.1177/1744987106059459
- Stanley, D. (2009). Leadership: Behind the mask. *ACORN: the Journal of Perioperative Nursing in Australia*, 22(1), 14-16..
- Stiles, M. K. (1990). The shining stranger: Nurse-family spiritual relationship. *Cancer Nursing*, 13(4), 235-245.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications.
- Streubert, H., & Carpenter, D. (1995). *Qualitative research in nursing*. Philadelphia: J.B. Lippincott Company.
- Sturmberg, J. P., & Martin, C. M. (2009). Complexity and health – yesterday's traditions, tomorrow's future. *Journal of Evaluation in Clinical Practice*, 15(3), 543-548. doi: 10.1111/j.1365-2753.2009.01163.x

- Sumners, A. D. (1990). Professional nurses' attitudes towards humour. *Journal of Advanced Nursing*, 15(2), 196-200.
- Sutherland, L. L., & Gilbert, V. (2008). The good patient -- bad patient: a consequence of following the rules of a clinical practicum. *Annual Review of Nursing Education*, 6, 83-101.
- Tang, K. C., Duffield, C., Choucair, S., Chen, J., Creegan, R., Mak, C., et al. (1999). Nursing as a career choice: Perceptions of school students speaking Arabic, Serbo-Croatian, Spanish, Turkish or Vietnamese at home'. *Australian Health Review*, 122(9), 107-121.
- Taylor, B. (1994). *Being human: Ordinarity in nursing*. Melbourne: Churchill Livingstone.
- Thomas, C. (2010). Teaching nursing students and newly registered nurses strategies to deal with violent behaviors in the professional practice environment. *Journal of Continuing Education in Nursing*, 41(7), 299-310.
- Thorne, S. E. (1988). Helpful and unhelpful communications in cancer care: The patient perspective. *Oncology Nursing Forum*, 15(2), 167-172.
- Thorne, S., & Paterson, B. (1998). Shifting images of chronic illness. *Image: Journal of Nursing Scholarship*, 30(2), 173-178.
- Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.
- Tomey, A. M. (2006). Nursing theorists of historical significance. In A. M. Tomey & M. R. Alligood (Eds.), *Nursing Theorists and Their Work* (6th ed., pp. 50-70). St Louis: Mosby Elsevier.
- Tripp, D. (1994). Teachers' lives, critical incidents and professional practice. *Qualitative Studies in Education* 7(1), 65-76.
- Trojan, L., & Yonge, O. (1993). Developing trusting, caring relationships: Home care nurses and elderly clients. *Journal of Advanced Nursing*, 18, 1903-1910.
- Vallido, T., Wilkes, L., Carter, B., & Jackson, D. (2010) Mothering disrupted by illness: a narrative synthesis of qualitative research. *Journal of Advanced Nursing*, 66(7), 1365-1445
- von Essen, L., & Sjöden, P.-O. (1991a). Patient and staff perceptions of caring: review and replication. *Journal of Advanced Nursing*, 16(11), 1363-1374. doi: 10.1111/j.1365-2648.1991.tb01566.x
- von Essen, L., & Sjöden, P.-O. (1991b). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies*, 28(3), 267-281. doi: 10.1016/0020-7489(91)90020-4

- von Essen, L., & Sjoden, P.-O. (2003). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies*, 40(5), 487-497.
- Waldenström, U., Brown, S., McLachlan, H., Forster, D., & Brennecke, S. (2000). Does team midwife care increase satisfaction with antenatal, intrapartum, and postpartum care? A randomized controlled trial. *Birth*, 27, 156-167.
- Walker, K. (2005). Reaching for the stars: Career advancement and the registered nurse. *International Journal of Nursing Practice*, 11, 185-190.
- Walrath, J. M., Dang, D., & Nyberg, D. (2010). Hospital RNs' experiences with disruptive behavior: A qualitative study. *Journal of Nursing Care Quality*, 25(2), 105-116. doi: 10.1097/NCQ.0b013e3181c7b58e
- Watkins, M. J. (2000). Competency for nursing practice. *Journal of Clinical Nursing*, 9(3), 338-346.
- Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston: Little, Brown.
- Watson, J. (1985). *Nursing: Human science and human care*. Boulder: CT: Appleton-Century-Crofts.
- Watson, J. (2009). *Assessing and measuring caring in nursing and health sciences* (2nd ed.). New York: Springer Publishing Company.
- Watson, R., Deary, I. J., & Hoogbruin, A. L. (2001). A 35-item version of the caring dimensions inventory (CDI-35): Multivariate analysis and application to a longitudinal study involving student nurses. *International Journal of Nursing Studies*, 38, 511-521.
- Watson, R., Deary, I. J., Hoogbruin, A. L., Vermeijden, W., Rumeu, C., Beunza, M., et al. (2003). Perceptions of nursing: A study involving nurses, nursing students, patients and non-nursing students. *International Journal of Nursing Studies*, 40, 133-144.
- Watson, R., Deary, I. J., & Lea, A. (1999). A longitudinal study into the perceptions of caring among student nurses using multivariate analysis of the Caring Dimensions Inventory. *Journal of Advanced Nursing*, 30(5), 1080-1089.
- Watson, R., & Lea, A. (1998). Perceptions of caring among nurses: The influence of age and sex. *Journal of Clinical Nursing*, 7(1), 97-98.
- Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing*, 39(5), 421-431.

- Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, 53(4), 459-469. doi: 10.1111/j.1365-2648.2006.03740.x
- Webb, C., & Hope, K. (1995). What kind of nurses do patients want? *Journal of Clinical Nursing*, 4(2), 101-108.
- While, A. E. (1994). Competence versus performance: Which is more important? *Journal of Advanced Nursing*, 20(3), 525-531.
- Wierda-Boer, H. H., Gerris, J. R. M., & Vermuslt, A. A. (2009). Managing multiple roles: Personality, stress, and work-family interface in dual -earner couples. *Journal of Individual Differences*, 30(1), 6-19. Retrieved from http://0-ft.csa.com.prospero.murdoch.edu.au/ids70/resolver.php?sessid=n34tvma7cp4dm5llib1bbsaim6&server=csaweb107v.csa.com&check=ceb6a9ca41a68edda2d420ad694019f7&db=psycarticles-set-c&key=JID%2F30%2Fjid_30_1_6&mode=pdf
- Williams, A. M. (1996). *The delivery of quality nursing care: A grounded theory study of the nurse's perceptions*. Curtin University of Technology, Perth.
- Wilson, J., & Retsas, A. (1997a). Australian nurses' personal constructs about effective nurses-A repertory grid approach. *Journal of Professional Nursing*, 13(3), 193-199. doi: 10.1016/s8755-7223(97)80071-3
- Wilson, J. M., & Retsas, A. P. (1997b). Personal constructs of nursing practice: A comparative analysis of three groups of Australian nurses. *International Journal of Nursing Studies*, 34(1), 63-71.
- Winskill, R. W. (2000). Is competency based training/education useful for workplace training. *Contemporary Nurse*, 9(2), 115-119.
- Winwood, P. C., & Lushington, K. (2006). Disentangling the effects of psychological and physical work demands on sleep, recovery and maladaptive chronic stress outcomes within a large sample of Australian nurses. *Journal of Advanced Nursing*, 56(6), 679-689. doi: 10.1111/j.1365-2648.2006.04055.x
- Woolcott, H. F. (1994). *Transforming qualitative data: Description, analysis, and interpretation*. Thousand Oaks: Sage Publication.
- Yin, R.K. (2003). *Case study research: Design and methods*. (3rd ed.). Thousand Oaks, CA: Sage.
- Zhang, Z., Luk, W., Athur, D., & Wong, T. (2001). Nursing competencies: Personal characteristics contributing to effective nursing performance. *Journal of Advanced Nursing*, 33(4), 467-474.

APPENDICES

Appendix A

Consent Form

Title: The Good Nurse: Evidential Cues

I..... agree to participate in the above study. I have read and understood the study information and any questions I have asked have been answered to my satisfaction. I understand that I may withdraw from the study at any time without prejudice.

I agree that the data gathered for the study may be published provided my name or other identifying information is not used.

I understand that I will be interviewed and the interview will be audio recorded. I also understand that the recording will be erased once the interview is transcribed.

Signed..... Date.....

Signature of Investigator..... Date.....

All study participants will be provided with a copy of the consent form for their personal records.

Appendix B

Demographic Questionnaire

1. **Gender** ☐ male ☐ female

2. **Age at last birthday** _____

3. **Country of birth** _____

4. **Cultural background** ☐ Middle-Eastern ☐ Indigenous
☐ South American ☐ North American
☐ Northern European ☐ Pacific Islander
☐ Eastern European ☐ African
☐ Southern European ☐ Anglo Celtic
☐ New Zealander ☐ Asian
☐ Australian ☐ other (specify)

5. **Highest educational level** ☐ Less than High School
☐ Junior High School (yr 10)
☐ Senior High School (yr 12)
☐ Trade or TAFE
☐ Diploma
☐ Degree...please
specify _____
☐ Higher Degree

6. **Are you participating in this study as a:**
☐ Patient ☐ Medical Practitioner
☐ Physiotherapist ☐ Social Worker
☐ Other (please specify) _____

For patients only:

7. How long were you in hospital? _____(days)
8. How long ago were you a patient in the hospital?
_____(weeks)
9. Type of occupation ☐ Clerical ☐ Retired
 ☐ Labourer ☐ Retail
 ☐ Trade ☐ Management
 ☐ Professional ☐ Homemaker
 ☐ Other (please specify:) _____

For other participants:

10. .In what year did you first register to practice as a health professional?.....
11. How many years have you worked as a health professional?.....
12. How often are you in contact with registered nurses/mental health nurses?
☐ Daily ☐ Weekly
☐ Monthly Other (please specify)_____

Thank You

Appendix C

Letter - Validation of Findings – Phase II

Satisfactory, good and outstanding nurses: Perceptions of nurses, their colleagues and patients

Dear

Thank you for participating in my PhD study which I commenced at Edith Cowan University but am now completing at Murdoch University. The interviews that I conducted with nurses, doctors, allied health professionals and patients were very informative and I wish to thank you again for participating in my study. I am progressing along well with the final analysis of the information that I collected from you and the other participants. I am making contact again with you to provide a summary of the findings of my study.

Providing participants with a summary of the findings of studies in which they have participated is an important way to acknowledge the contribution that people make to research. In the attachment to this letter you will find enclosed a summary of the findings which is based on the information provided by all participants and it would be great if you could take time out to read the summary.

I would like to hear from you again with regard to the findings of the study.

Although I didn't originally indicate that I would be contacting you again, I am interested in making contact with you by phone or in person regarding what you

think about the findings from the interviews conducted. I have provided a consent form which you need to complete and sign so that I may go ahead and contact you to discuss the findings of the study. There is also a place for a contact phone number just in case your phone number has changed. Please send this back to me in the reply paid envelope provided.

I would also appreciate you writing down comments on the blank sheet provided so that when I phone you we can talk about your comments. When I call, you may like to tell me about what you think about the findings or talk to me about any discrepancies that you have noted. You may also wish to post your comments in to me in the reply paid envelope provided if you do not wish to be contacted by phone. This would be particularly helpful in case I am not able to make contact with you by phone. There is no direct benefit to you in participating further but it will help to strengthen the findings of the study if you are able.

If you are willing to comment further, could you please complete the consent and contact details. My supervisor and I are happy to discuss with you any concerns you may have on how this study has been conducted. If you wish to talk to an independent person about your concerns you can contact Murdoch University's Human Research Ethics Committee on 9360 6677 or email ethics@murdoch.edu.au.

Thank you again for your help this far. I hope that you are able to spare just a little bit more of your time to complete the above, so that I am able to gather this important information for my research.

Yours Sincerely

Kristina Medigovich

Address details

xxxxxxx. WA. 6xxx

PhD Student

Ph: 9xxx xxxx (work)

Mobile: xxxx xxx xxx

Appendix D

Summary of Findings

Please take a few minutes to read the following which is a summary of the findings from the interviews regarding outstanding, good and satisfactory nurses. I was interested in your experience of outstanding, good and satisfactory nurses based on your contact with the nurses in your role as a doctor, nurse, occupational therapist, patient, physiotherapist, and social worker. The findings have a number of main themes and some sub themes under each nurse category.

Outstanding Nurses

I found six major themes in the data and underneath each theme there were often a number of sub themes.

1. *Sustaining a high level of performance.* Participants identified that outstanding nurses performed at a high level and enabled others to perform at a high level. One way was to maintain a safe environment.
 - (i) *Maintaining safe practice.* Participants valued the outstanding nurses' ability to maintain a practice environment which was safe. This meant slightly different things for the health professionals and the patients. For health professionals it meant safe from aggressive behaviour from patients and staff. For patients it meant that the nurse practised in a way which led to the patient feeling confident, and therefore safe in the care of the nurse. For both patients and health professionals, this also meant that everyone felt safe when the nurse was able to manage and cope in situations where difficulties or the untoward arose.
 - (ii) *Ensuring care requirements are met.* Outstanding nurses were seen to be nurses who ensured that all patient care requirements were met even when there was limited

time. This they achieved in their own practice often through skilful planning and communication.

2. *Modelling exemplary professional behaviours.* Outstanding nurses demonstrated that they valued their own profession of nursing and thought that nursing was important. The nurses had a positive attitude to the work of nursing and were enthusiastic about addressing the care needs of patient. They were compassionate and persevered to achieve good patient outcomes. They showed concern for others, both patients and their families, and showed respect for others both patients and staff, regardless of the circumstances at the time. Outstanding nurses were seen to be consistently dependable and reliable.
3. *Balancing the personal and the professional.* Nurses who performed at an outstanding level were seen to have a high level of personal competence, and the attributes they brought to the workplace contributed to the workplace being an enjoyable place to be. The nurses were happy to be at work. If there was unhappiness in their personal lives, this had no influence on their performance at work. The outstanding nurse was genuine in her/his relationships with people and showed personal warmth toward patients. They seemed to have a high level of energy and were able to attend to do things quickly and without fuss. Outstanding nurses were always well groomed – fulfilling an expectation that the nurse will ‘look the part.’ They were patient centred in their approach to the care of patients, and therefore would always consult the patient about the plan of care. Outstanding nurses were found to be very approachable by staff, although this did not rate as highly for the patients. However, both patients and health professionals commented that outstanding nurses had a generosity of spirit and were obliging and helpful. The

nurses also showed resilience by being able to respond to any type of situation without giving the appearance that they were overwhelmed.

4. *Managing self and others.* Outstanding nurses managed their emotions well and were never seen to panic and become poor managers, or not cope. They were described as being on an 'even keel', and remained calm in demeanour. The nurses were also renowned for the support that they offered others, including patients and their fellow health professionals. Patients identified that outstanding nurses were highly visible by being attentive and constantly in attendance at the bedside. Outstanding nurses were also seen to be able to manage the ward well, and this was particularly appreciated by the health professionals.
5. *Forming personal and therapeutic relationships.* Outstanding nurses formed relationships which were more personal than just engaging in conversations about immediate requirements or transacting information. The high level of interpersonal skills of outstanding nurses, particularly with regard to verbal communication, was seen by health professionals and patients to be of therapeutic benefit to the patient. The way the outstanding nurses communicated was described as easy, (easiness in style) friendly, open and transparent, and they were described as skilful communicators in difficult situations. Outstanding nurses were able to detect non verbal cues, generally 'pick up on things that weren't spoken' and importantly, respond to those cues.
6. *Clinical knowledge and competence.* Outstanding nurses were credible and competent in the provision of care, and had greater knowledge than other registered nurses. The nurses demonstrated a higher level of clinical knowledge in their area of practice, which everyone identified as being extremely important. These nurses were likely to have completed further education or be in the process of doing so. They also

undertook patient and family teaching, and were able to monitor the patient's condition while undertaking other routine work, which a less experienced or competent nurse may not be able to undertake.

Good Nurses

I found five major themes for good nurses. The good nurse was described by participants as a nurse who performed well. The general view of a good nurse is someone who is competent clinically, knowledgeable, a good communicator, a nurse who works collaboratively, and is caring. Often the comments from the participants indicated a qualifier, or some reservation. Some nurses would have been considered as outstanding, except for a limitation.

1. *Clinical competence.* An area of limitation was in assessment skills. Examples given were: some nurses did not assess/look at wounds; another area was in anticipating aggressive patient behaviour; and managing technology was sometimes done inconsistently.
2. *Knowledge.* Good nurses were limited in their ability to teach and educate patients and families, as their knowledge was often more general, and not specific.
3. *Communication.* There was a difference between how outstanding nurses and good nurses communicated. The good nurse was seen to be someone who was selective about whom they would have an open style of communication with, while others transgressed personal and professional boundaries by divulging personal information. Outstanding nurses always greeted people and initiated conversation, whereas good nurses were seen as more often greeting people but not initiating conversation. The good nurse was less likely to be able to deal with difficult situations.
4. *Working collaboratively.* The good nurse was more likely to be more focussed on her/his own work/role/patients. While doing that well, they seemed fully engaged

with their work, and collaborated with the rest of the team less than the outstanding nurse. In some cases, their communication skills limited their ability to communicate as effectively as the outstanding nurse.

5. *Caring.* Although most good nurses were described as being caring there were also some exceptions. For example, a very competent nurse was described as showing little concern for the patients by rushing when caring for the patients. Another was described as not having the same 'input' because of being distracted by personal issues, with less evident commitment.

Satisfactory Nurses

There were five themes identified with regard to satisfactory nurses. Satisfactory nurses were perceived to perform at a basic minimum standard. Although they were practising at a safe level, they were described by seventeen participants as '*just doing the job*' or '*someone who does their job*', not providing any additional care beyond tasks. The description of satisfactory nurses indicates that the expectations of patients and health professionals were not high.

1. *Primarily attending to physical care.* Satisfactory nurses primarily attended to the physical care of a patient to a minimum standard and were selective in who they provided care to, preferring patients with less complex care needs. They provided care according to the nursing care plan, and reported problems to other health professionals, but were limited in their repertoire of skills, and showed less caring and empathy. Satisfactory nurses were able to do tasks such as the measurement and recording of routine observations. However, while completing tasks at the bedside they were not able to provide the additional support to patients which evolved through communication.

2. *Providing a minimum standard of care.* As well as being task orientated participants saw the satisfactory nurse as only meeting the minimum standard of

care. The nurse would be able to administer medications on time, measure and record blood pressure, and give standard treatments without anticipating or engaging in additional patient requirements. The nurse performing at a satisfactory level was able to prioritise care in terms of tasks, but may not identify that the patient priority was to provide emotional support and comfort for a patient who was stressed. Some satisfactory nurses did not provide all the assistance that was required by patients, which may have been due to poor assessment skills, as their repertoire of skills was mainly at the task level.

3. Selective caring. Satisfactory nurses were more inclined to choose to look after patients who had less complex care requirements. Often the satisfactory nurse was energised by the very technical, but was not energised by the mundane or more everyday aspects of the role.

4. Lack of demonstrated problem solving skills. A further limitation among satisfactory nurses was their lack of problem solving skills, and may take longer to act on and identify problems/issues. When a problem arose the problem was passed on to senior staff.

5. Limited personal and interpersonal capabilities. Satisfactory nurses exhibited a lack of interpersonal skills. They were not always professional in how they engaged with other professionals and patients and their relatives. Other staff found them less approachable, and therefore satisfactory nurses were not able to model team participation behaviours well.

Appendix E

Consent Form – Phase II

Satisfactory, good and outstanding nurses: Perceptions of nurses, their colleagues and patients.

Participant

I have read the participant information sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed. I understand that I do not have to answer particular questions if I do not want to and that I can withdraw at any time without consequences to myself.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required by law.

Signature of Participant

Date

Chief Investigator

I have fully explained to _____ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

Signature of Investigator

Date

Print Name

Position